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**M.Sc. Applied Social Work**

**M.A. Social Policy**

**A Case Study of the Statutory Review System for Older People in Care Homes  
in One Local Authority**

**Doctor of Philosophy**

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**Health and Social Care**

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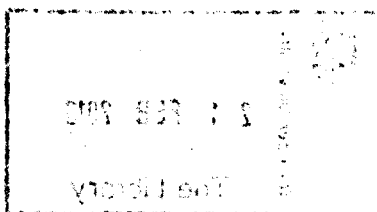
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# **A Case Study of the Statutory Review System for Older People in Care Homes in One Local Authority**

**Peter Scourfield**



**MOITATON**



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# Chapter One: Introduction

"The views of users and carers should be central to the process, so the review should be organised to enable them to contribute fully."

*Care management and assessment: Managers' guide*, Department of Health (1991a: 48).

Although not defined or required in legislation, reviews of older people's care home placements by local authorities are a legacy of the Community Care reforms of the 1980s and 1990s in the UK. Following the implementation of the NHS and Community Care Act 1990, 'care management' became the official process by which local authorities assessed people's needs, determined their eligibility for service, formulated a care plan and put into place appropriate care services to meet any eligible needs. Official guidance accompanying the Act stated that, along with 'assessment, 'care planning, 'implementation' and 'monitoring', 'review' was a key stage in the care management process. Reviews are, therefore, described as 'statutory' in this study because they are part of a process which local authorities are required to follow under their statutory responsibilities to provide care services to adults.

The motivation to research statutory reviews for older people in care homes came originally from having attended several such reviews both as a social worker and a relative. My observation was that, whilst a review is meant to present the older person with an opportunity to express their views about the quality of care, far from being 'central to the process', the older people often appeared to be marginal figures in their own review. Also it was not always clear whether the older person fully

understood the function of the review. For example, many believed that it was a review of 'them' rather than whether the care provision arranged for them continued to meet their needs. Therefore, despite being the subject of the review, it appeared that, for various reasons, the older person could easily get 'lost' in the process. From the reviewer's perspective, they were often meeting the older person for the first time and, with little time to make effective contact with other review participants, relying chiefly on case records to provide them with background information, before working their way through a prescribed format. Reviews, therefore, appeared to be potentially important pieces of work but undertaken under challenging conditions for all concerned.

Using a mixed method approach, which produced interview, observational and documentary data, this small scale qualitative study was designed to explore how the statutory care home review system operated. The study drew on the perspectives and actions of various stakeholders, including that of the older person. Given the observed lack of fit between policy and practice in terms of the requirement to make service users 'central to the process' and enable them to 'contribute fully', the study also set out to assess the relevance of the theory of 'street-level bureaucracy', as developed by Lipsky (1980), in understanding how review policy was put into practice.

## **Aim and objectives**

The broad aim of the project was to obtain an understanding of how the system of statutory care home reviews operated and was experienced by those involved in it.

Specific objectives were:

- To explore and explain the various purposes that statutory care home reviews serve in terms of both policy and practice.
- To examine and compare different stakeholder perspectives on the review process; including managerial, practitioner; service-user, relatives and care home staff.
- To observe, in particular, the roles of the reviewer and the older person in the review process.
- To assess the relevance of 'street-level bureaucracy' (Lipsky, 1980) as a conceptual lens with which to analyse and explain the practice of statutory care home reviews, particularly in respect of the use of discretion.

## **Outline of the thesis**

Chapters Two and Three provide a review of relevant literature in order to place statutory care home reviews in as full a context as possible and also to develop a conceptual framework with which to better understand how they operated in the particular local authority under study. Given the range of subject areas which, potentially, inform this study, for example, community care, older people, care homes, adult social care policy and adult social work, the literature review is, by necessity, selective.

Chapter Two begins by situating the statutory care home review in its broader policy and practice context and examines both the reasons *behind* and the enduring *impact* of reforms brought about by community care legislation in the 1990s. It also discusses the impact of key policy developments in adult social care that have happened in the 2000s, such as 'modernisation' and 'personalisation', 'safeguarding', the *National Service Framework for Older People* (Department of Health, 2001b) and the impact of the Mental Capacity Act 2005. The discussion also includes an examination of the changing regulatory regimes in which adult social care (including care home provision for older people) is delivered. Reflecting on the many changes that have occurred in this sector, I foreground the concept of 'dispersal' (Clarke and Newman, 1997) which refers to how 'proxies of state power' (for example, purchasers, providers and regulators of care) have multiplied over the decades leading to power being more widely dispersed throughout a more fragmented sector with a blurring of accountability for care quality.

As explained above, officially, 'review' is an integral stage in the care management process instigated as part of the community care reforms. Therefore, Chapter Two examines selected literature on care management in more detail, including the often repeated claims that, in a heavily managerialised sector, care management has developed into a bureaucratised and proceduralised 'tick box' process, ill-suited to enabling care that is truly person centred.

The next part of Chapter Two focuses on the changing care home sector for older people. The discussion includes an explanation of how the structure of the care home market has changed significantly since the 1980s and also how the

characteristics of care home residents have changed significantly over the same period of time.

Lastly, Chapter Two situates the study in its policy, organisational and demographic context at the local level and explains key characteristics of the field. The picture that emerges is of a local authority (referred to throughout this study as 'the County') having to implement a range of policy initiatives whilst undergoing a succession of organisational changes and within the context of significant financial constraints.

Chapter Three introduces and discusses the theory of street-level bureaucracy (Lipsky, 1980). It starts by discussing both the origins and key concepts that form the basis of the theory. Lipsky argues that in order to implement policies that are often ambiguous and conflicting, under conditions of limited resources, 'street-level bureaucrats' (front-line practitioners) in public service organisations such as Social Services departments necessarily have to use their discretion in making decisions at the micro level. As a consequence, through the exercise of their 'discretion', argues Lipsky, the practice of street-level bureaucrats effectively *becomes* the policy.

Primarily because of this, 'street-level bureaucracy' has been adopted as a useful lens through which to investigate social services in the UK and other countries.

However, a review of key studies in this area indicates that Lipsky's original thesis, whilst still broadly applicable, requires modification in certain key areas in order to continue to be relevant. Chapter Three concludes by arguing that, with certain important modifications to bring it up to date and to broaden the scope of where discretion is exercised, the theory of 'street-level bureaucracy' remains a useful tool with which to understand how policy is implemented in care home reviews.

Chapter Four begins by restating and clarifying the aim and objectives of the research followed by an explanation of how the methodological decision-making developed. After conducting a successful pilot study which involved observing two care home reviews, subsequent difficulties in accessing the field required the research to be redesigned. It was decided to develop a case study based on observations but also using additional contextual interview and documentary data from the County review system. I return to discuss critically the issues in respect of gaining access and what this revealed about the field in Chapter Nine. The discussion in Chapter Four focuses on the methods of data collection used, ethical considerations, the method of data analysis and the issues of how the findings might be generalised. Thereafter, attention is given to the ontological and epistemological assumptions underpinning the study. The chapter ends with a discussion of my relationship to the field as a researcher, highlighting issues to which I return in more detail in Chapter Ten.

The next three chapters (Five, Six and Seven) discuss the empirical findings, identify key themes and reach conclusions concerning the research questions. Chapter Five draws on interview data from a range of different review stakeholders: care managers, care home managers, care home residents, the relatives of residents and managers of different levels in the County. These data revealed different reasons why reviews took place, the various interpretations of what a review's purpose was and the impact of the continuously changing policy and organisational context in which care home reviews took place. Analysis of these data enabled a better understanding of key themes with, perhaps, the most important to emerge being the

challenge facing managers and practitioners of balancing 'quality and quantity'. It was found that the compromises associated with meeting this challenge created tension in various points in the review system. Identifying the pressure points that caused tension for those involved, provided a context to better understand why and how the various stakeholders exercised their discretion pragmatically to manage the pressures and resolve the tensions in the system. This discussion is elaborated further in Chapter Eight.

Chapter Six examines more closely the practice observed in three actual reviews. As explained, the first two observations took place as part of the pilot study in 2007. The third observation took place in 2009. After each observation, where possible, the review participants were interviewed. In addition, in each case, the completed review documentation was collected and examined. Based on both observation of and interviewing care managers the core of the review process could be seen as gathering, processing and checking information from different sources and then deciding whether the placement was still meeting the older person's needs. The requirement for discretion was evident in that, although, notionally, working to a standardised procedure laid down in departmental guidelines, care managers, necessarily had to make a series of micro-decisions at each stage of the review process. The Chapter discusses each different stage in the review process in more detail, highlighting both the potential tensions and the opportunities for the use of discretion in each.

The focus of Chapter Seven is on the role played by older people in their reviews and, where possible, gaining a sense of what they understood the purpose of



reviewing to be. Owing to their mental capacity it was only possible to interview one of the three older people whose reviews I observed. I therefore decided to supplement these data by interviewing two other older care home residents who had recently been involved in a review. The chapter compares the situation of the older person who had mental capacity with the situation of those who lacked capacity. The two sets of findings are compared and I draw conclusions about the impact of the review process and the nature of participation for older people in the process.

Chapter Eight engages in an analytical discussion of the findings and begins by summarising and discussing the key themes and findings emerging from the previous chapters in relation to how they helped answer the questions specified in the first three research aim and objectives set out earlier in this Chapter. In the second section the discussion then moves on to a critical consideration of the fourth research objective which was to assess the relevance of Lipsky (1980) as a conceptual lens. The second part of the discussion develops further the ideas introduced in Chapter Three that, in the context of a public sector in the UK where power is now more dispersed amongst various statutory and non-statutory actors, the concept of street-level bureaucracy, as it was originally developed by Lipsky, needs to continue to be updated and refined.

To complete the discussion, the third section focuses on the situation of the older person who is at the centre of the statutory care home review but who, for various reasons, is also the least powerful actor in it. I argue that review practices, far from being a means of empowerment for older people, can, paradoxically, often end up becoming a source of disempowerment, if not oppression. Some suggestions are

made that could improve the review experiences of older people and ensure that their interests are better promoted. However, in making these suggestions, it is recognised that they would be unlikely to be effective unless there was significant change in the overall way the adult social care operates.

Chapter Nine returns to the difficulties experienced in negotiating field access and the lessons that could be learned from them. Negotiating field access to observe reviews and to interview older people who had been in a review was a more protracted process than anticipated. However, this process generated useful data which, following analysis, provided further insights into the exercise of street level bureaucracy and how the statutory care home review system operated in the County.

Chapter Ten concludes the thesis by reflecting critically on the whole research process. Points considered include: the impact of my personal and professional 'situatedness' on the study, thoughts about dissemination and what I would do differently if I were to undertake similar research again. I finish by making certain suggestions for further research based on the issues raised in the study.

### **Terminology used**

Throughout the thesis the local authority in which the study was conducted is referred to as 'the County'. The local authority practitioners who undertake reviews are mainly referred to as 'care managers' which was their job role and job title at the time of the study. However, they are also referred to as 'practitioners' or 'reviewers' when this is more appropriate to the discussion.

## **Chapter Two: The Context**

### **Introduction**

This chapter reviews relevant academic literature and policy documentation in order to situate statutory care home reviews in a broader policy and practice context at both the national and local level, as well as examining the political and demographic context in which key developments have taken place. The discussion begins by focussing on the origins and the impact of the community care reforms of the 1990s. This highlights the processes of marketisation and privatisation that, amongst other effects, have led to the adult social care sector becoming more fragmented in recent decades, with power being dispersed amongst more 'actors' as a consequence.

The discussion then focuses on key policy changes that have impacted upon the adult social care sector since the 1990s, for example, New Labour's 'modernisation' agenda (Department of Health, 1998) and also the continually evolving social care regulatory regimes. This discussion highlights the many challenges faced by those responsible for implementing social care policy in practice. It also draws attention to and helps understand the numerous organisational restructurings that modernisation and other policies have necessitated at the local level. Illustrative examples of how this has impacted locally in the County are provided towards the end of the chapter.

The focus then progresses to a critical discussion of the origins and development of 'care management' which is the chief means by which policy on community care is implemented in practice. 'Review' forms an important element in the care

management process, however it has traditionally received less attention than the other elements, for example, assessment and care planning.

As the focus of the study is specifically concerned with statutory reviews of older people's placements in care homes, the chapter discusses key changes that have occurred in the care home market and the care population since the introduction of community care, most notably drawing attention to the fact that care homes are now mainly privately owned and the older care home population has more complex care needs than in previous decades. Following a discussion of key issues that have emerged relating to the challenges of establishing and maintaining standards of care in the care home sector, the chapter concludes by focusing on and explaining the specific local characteristics of the field under study.

## **Developments in community care**

The origins of the current statutory care home review can be traced to the radical reforms to which the system of adult social care was subjected in the 1990s through the introduction of the NHS and Community Care Act 1990. Residential and nursing home care had formed an important part of the adult social care system since the creation of the welfare state in Britain. In the post-war period the residential care home sector was largely, but not exclusively, state-run and was often the only option available for older people who were unable to look after themselves and who lacked support from their family. The quality of care provided was variable and delivered in surroundings of low material standards (Townsend, 1962; Willcocks *et al.*, 1987; Means and Smith, 1998; Johnson, *et al.*, 2010a).

The variable quality of the care received by older people in institutional settings in the 1960, 1970s and 1980s needs to be understood in a wider context where 'social work' with older people in general received 'more superficial attention than those from other client groups' (Bowl, 1986: 129). More specifically, according to Bowl, before the community care reforms were implemented, social work with older people was largely:

...routine, unglamorous or even casual and is often allocated to unqualified social work or ancillary staff. Assessment is frequently scanty and limited to consideration for a particular scarce resource rather than of the all-round needs of the individual, whether it be assessment for aids and adaptations, meals-on-wheels, residential accommodation or day care. In general, social work for these old people consists of the mobilisation of practical services and any prolonged contact with a social worker is dependent on the time taken to mobilise the resource. Often, there will be no follow-up by the social worker to see if the service being offered is appropriate, or indeed is even being used (*ibid*).

This rather impoverished approach to 'social work' with older people in the 1970s and 1980s was borne out by studies carried out at the time. For example, referring to a study carried out for the Department of Health and Social Security by Parsloe and Stevenson (1978), Rowlings (1981) remarked that the attitudes of social workers and social work students towards social work with older people revealed evidence of negative stereotyping of old age. Social work with older people seemed to come a 'poor third' after social work with children and mental health social work (Rowlings, 1981: 22). Lymbery (2005) also discusses how the low status social work with older people was reflected in the newly-introduced generic social work training courses which included 'little on the needs of older people' (p.128). Therefore, it would be

wrong to create the impression that, prior to the official implementation of 'Community Care', there was a 'golden age' of social work with older people. This period, if anything, as Bowl (1986) and Lymbery (2005) suggest, reflected an underlying ageist attitude to this area of social work. Also, over the course of the 1980s, policy changes in the wider welfare system skewed outcomes for older people requiring care and support. Specifically, the 'perverse incentives' created by changes to the social security regulations contributed to a sharp increase in the state-funded residential and nursing home population<sup>1</sup>, with rising demand leading to a rapid expansion in private care homes (Lewis and Glennerster, 1996; Peace, *et al*, 1997; Sharkey, 2000; Means *et al.*, 2008). By 1991 the annual cost to the social security budget of supporting care home residents had risen to £1.3 billion, having been less than £10 million a decade previously. Costs to the taxpayer 'threatened to spiral out of control' (Qureshi, 2002: 706).

Reports commissioned by the Conservative government (e.g. Audit Commission, 1986 and Griffiths, 1988) largely reflected the 'New Right' political ideology of the times, in that market solutions were proposed, privatisation encouraged, 'targeting' was favoured and a strongly managerialist approach advocated both to ensure cost effectiveness and to 'discipline' social work professionals by enabling managerial concerns to predominate over professional ones (Langan, 1990; Langan and Clarke, 1994; Lewis and Glennerster, 1996; Clarke and Newman, 1997; Jones, 1999; Means *et al.*, 2008). A concern about the financial cost of care became bound up with 'catastrophising' discourses relating to the challenges faced by an ageing

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<sup>1</sup> The number of people aged over 65 resident in privately run care homes grew from 18,800 in 1975 to 119,900 in 1990 – Halsey, A. and Webb, J. (2000) (Eds.) *Twentieth Century Social Trends*, Basingstoke: Palgrave Macmillan, (p.516).

population – commonly referred to as the 'demographic time bomb' (e.g. Ermisch, 1990). Means *et al* (2002) explain that rising costs to local authorities of providing both residential and home care services had caused service providers to consider seriously the targeting and rationing of services (particularly in the developing area of home care) long *before* the emergence of the *Griffiths Report* (1988) and *Caring for People* (Department of Health, 1989). As Means *et al.* (2002) explain:

... governments were becoming convinced that the kind of broad welfare service growth for older people associated with the early 1970s could not be sustained in the future, even with a significant economic upturn. This message was rammed home by *A happier old age* (DHSS, 1978), the consultative paper produced by the Labour government a year before the election of the first Thatcher administration. The picture presented by this document was not of a welfare system that could provide domiciliary and other welfare services as a right and free of charge. Instead, the context was one of a rising overall older population, combined with significant increases in the numbers of the 'old old'. The paper pointed out "that roughly speaking just over £10,000 million, or a third of the total public expenditure on the main social programmes, is attributable to elderly people" and that "within the health and personal social services the average cost of care and treatment of a person aged over 75 is seven times that of a person of working age" (p 10) (p.37).

Therefore, the roots of the 'demographic time-bomb' discourse, associated with the costs of people living longer, can be traced to at least the 1970s, if not earlier. Against this general background, the concern in the 1980s and 1990s about spiralling costs of residential care which were expressed in official policy on

Community Care meant that, from 1993, the responsibility for funding care home residents no longer rested with the social security budget but was transferred to local authorities. The newly introduced process of 'care management' (Sharkey, 2007) would require local authorities to first assess that applicants for care services met specific eligibility criteria before public funding was spent on care provision.

However, pressure to reduce costs to the public purse, was not the only driving force behind the move towards community care. Other significant drivers (at least in policy rhetoric) included the desire for the system to be 'needs-led' rather than 'service-led', to promote individual choice and self-determination and the belief that 'the community' was a more appropriate setting to care for vulnerable people rather than institutions (Lewis and Glennerster, 1996; Qureshi, 2002; Means *et al.*, 2008, Means and Smith, 1998; Johnson *et al.*, 2010).

Whilst the use of institutional care retained support from some quarters (Wagner, 1988), 'deinstitutionalisation' discourses had been emerging from different adult service-user groups, professionals and academics campaigning for the use of community-based solutions over more traditional institutional responses to the needs of vulnerable groups in society (Bornat, *et al.*, 1997; Means and Smith, 1998).

However, the exact meaning of 'community-based' became highly contested, with some seeing 'community' as meaning, predominantly female, family carers expected to take up caring responsibilities (Bornat, *et al.*, 1997; Orme, 2000). Nevertheless, the appeal of the de-institutionalisation narrative ensured a favourable discursive background against which 'New Right' policies began to be implemented (McDonald, 2006). Therefore, whilst there is little doubt that keeping a tight lid on costs and



tightening eligibility for state assistance was always the principal concern (Oldman, 1991; Lewis and Glennerster, 1996), successive New Right governments in the 1980s and 1990s were able to effectively mobilise powerful discourses of 'choice', 'empowerment' and 'community', as well as 'value for money', to justify what were essentially neo-liberal reforms (Clarke and Newman, 1997). Whilst official rhetoric specifically commended the reforms for being 'needs-led' rather than 'service-led' as they were before (Department of Health, 1989), the likelihood of reduced access to services and increased charges following the reforms was not highlighted. It was therefore apparent that, inherent in community care policy, was the requirement for local authorities to balance the (potentially conflicting) agendas of meeting need and offering choice whilst, at the same time, rationing resources and keeping the lid on expenditure.

The community care reforms also substantially redefined the role of local authorities from being major providers of care to becoming commissioners of care. Local authorities would be the 'purchasers' in the newly created 'purchaser-provider split' (Langan, 1990; Lewis and Glennerster, 1996; Means *et al.*, 2008). It was this formulation that led to the system being described as a 'quasi-market'. In such situations, the local authority, not only acted as gatekeepers, they acted as 'proxy customers' assisting the service user to secure suitable care provision, which would, increasingly, be provided by the private and voluntary sectors. Whilst the introduction of competition was supposed to drive up quality, evidence has consistently failed to support this (Hadley and Clough, 1996; Help the Aged, 2007; CSCI, 2009).

Inspired by the values and processes of neo-liberalism, the creation of the 'purchaser-provider split' and a 'market' in social care illustrated well the shift, in recent decades, towards a 'dispersed state' (Clarke and Newman, 1997; Clarke *et al.*, 2000 and Clarke, 2004; Newman and Clarke, 2009). 'Dispersal' – and the subsequent blurring of accountability for public services – therefore occurs when state 'monopoly' providers of public services are deliberately broken up in order to create market-like conditions. Although, originated under the Conservative New Right regimes of the 1980s and 1990s, processes of dispersal in UK public services have been further developed under New Labour's<sup>2</sup> 'modernisation agenda' (Harris and White, 2009; Newman and Clarke, 2009). The effects of this, as Clarke explains, are that:

'Dispersal' multiplies the number of agents and agencies involved in delivering a particular service. It engages more agencies and agents as the proxies of state power (Clarke, 2004:36).

Clarke also argues that, as a consequence, dispersal has increased the 'number of (micro) decision-making settings' (*ibid* p.37), causing, amongst other things, problems of co-ordination and regulation. Therefore, the dispersal of power in social care has made the task of regulation of services more necessary but also more complex. In recent decades, it has been argued that the UK has become a 'regulatory state' (Moran, 2001) where, as public ownership diminishes and use of the market expands, new forms of regulatory control are required. This is reflected in

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<sup>2</sup> The Labour governments under the premiership of Tony Blair styled themselves 'New Labour' to signal a break from many of the policies of previous 'Old Labour' governments.

how care homes have been subject to continually changing regimes of inspection and regulation (Johns and Lock, 2008; Means *et al.*, 2008).

### **Community care and regulation**

The NHS and Community Care Act 1990 originally required local authorities to set up 'arm's length' registration and inspection units to regulate residential care homes (Means *et al.*, 2008). The Registered Homes Act 1984 (amended 1991) together with accompanying codes of practice, *Home Life* (CPA, 1985) *Better Home Life* (CPA, 1996) provided the standards for inspection. Both of these documents emphasised the need to keep the resident's 'care plan' under regular review, however guidance did not make a distinction between the care plan drawn up by the local authority and any internal care plans that a service provider might use. However, the 'arms-length' inspection units came under attack (not least by the private and voluntarily sector) for being insufficiently independent of the local authority (Means *et al.*, 2008). The incoming New Labour government was keen to 'modernise' the social services (Department of Health, 1998). Modernisation, according to Langan, (2000), was heavily influenced by the New Public Management principle of treating social services as a business and meant, amongst other things, reorganising social services around the principles of performance, standards and consumerism, as a consequence regulation became another defining feature of modernisation. New Labour's preoccupation with regulation led to several changes in social care regulatory regimes over a relatively short period of time.

Supported by recommendations of the Royal Commission on Long Term Care (Royal Commission on Long Term Care, 1999) New Labour introduced the Care

Standards Act 2000 which established the 'independent' National Care Standards Commission (NCSC) (Johns and Lock, 2008). Previously, for registration purposes, a distinction was made between 'residential' homes which were regulated by the 'arm's-length' local authority inspection units and 'nursing' homes which were regulated by health authorities. However, under the new legislation, all homes would thereafter be referred to as 'care homes', subject to both new regulations and new *National Minimum Standards* (NMS) (Department of Health, 2001a; 2003). In 2004 the NCSC was replaced by the Commission for Social Care Inspection (CSCI) which had a more 'developmental' remit (Johns and Lock, 2008). CSCI, in turn, was subsumed in 2009 into the newly-created Care Quality Commission (CQC) whose regulatory remit was expanded to include the full range of health and social care services. In 2010, by replacing the NMS with new *Compliance Guideline Criteria*, the government introduced a 'lighter touch' regulatory system that was more focused on 'outcomes' and required a greater element of provider self-assessment (Care Quality Commission, 2010a).

New Labour's preoccupations with both public sector performance and regulation also led to the introduction of the 'Performance Assessment Framework' (PAF) for Social Services in 1999 (Department of Health, 2012). Of particular relevance to this study, one of the, nearly two hundred, performance indicators (PIs) by which local authorities were evaluated was 'the number of existing clients receiving a review'<sup>3</sup> during the year' (AD40). New Labour's intensification of performance management regimes through all tiers of government meant that local authorities became acutely aware of the need to hit numerical targets on reviews (Harris and Unwin, 2009). In

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<sup>3</sup> This refers to all 'clients' in receipt of LA provided care, not just those in care homes.

2008, the PAF was replaced by the 'National Indicator Set' (Audit Commission, 2012; Department of Health, 2012) and whilst PI 'AD 40' was removed, performance cultures had already become firmly embedded in social services departments. For example, the County which is the subject of this study retained it as one of its internal performance indicators.

While the regulatory framework for adult social care in general and care homes in particular has evidently undergone continual revision, the effectiveness of all this activity in improving the overall quality of care for residents is open to question (Langan, 2000; Davis and Martin, 2008). As McDonald (2006) has noted, a large part of the failure to improve the quality of care received by service-users is because the system is 'based on needs rather than rights' (p.83). However, in the 2000s, it is possible to identify other reasons why regulatory regimes have been less than completely effective in maintaining standards of care - 'change' appears to be a significant factor. This is not only because of changing regulatory bodies and shifting criteria, but also because inspectors, often under official instruction, have reduced the frequency of inspections and, when inspecting, have been selective in which standards they have examined (Hadley and Clough, 1996; Help the Aged, 2007; Davis and Martin, 2008). In addition, some providers have, increasingly, been diverted away from 'first order functions' (i.e. caring for residents) by the expanded use of technologies of self-audit (Clarke *et al.*, 2000). The effectiveness (or otherwise) of the care regulator has been brought into even sharper focus in more recent years. Whilst CSCI and its predecessors were sometimes criticised for their over prescriptive approach (Means *et al.*, 2008), the Care Quality Commission which replaced CSCI in 2009, has been much criticised for, amongst other things, too light

a regulatory touch which, for example, saw a reduction in the number of care home inspections (National Audit Office, 2011; Parliament, 2011). This has led to the feeling both within and outside of Government in recent years that a regulatory 'gap' has emerged in adult social care. This is put into context by the National Audit Office (2011) in its report into the functioning of the *Care Quality Commission*. Amongst its key findings, the National Audit Office stated that:

7. The regulators for health and adult social care have been subject to considerable change in the last ten years. The Commission is the third regulator for each sector, although it is the first to cover both health and social care providers. The changes have created disruption for providers and confusion for the public.

8. The proposal to extend the Commission's role into new areas risks distracting the Commission from its core work of regulating health and adult social care.....

9. There is a gap between what the public and providers expect of the Commission and what it can achieve as a regulator.... (p.7).

Therefore, care homes for older people operate in a regulatory environment which, since the inception of 'community care', has been characterised by constant changes, none of which can be said to have guaranteed consistent quality of care for care home residents, but have, almost certainly, created a degree of confusion about where final accountability for care home quality lies.

## **Community care in the 2000s; New Labour and 'modernisation'**

It has been discussed how the community care reforms of the 1980s and 1990s, inspired by New Right ideology, promoted care markets, privatisation and recast 'clients' as 'consumers'. New Labour's agenda of modernisation, referred to above, not only meant the expansion of regulation, it positively embraced the discursive shift from welfarism to consumerism, believing that traditional ways of delivering social services had failed (Langan, 2000; Harris and White, 2009). By the turn of the century, Pithouse (2002) was to argue that, in many respects, social work was now a 'business'. He explains that:

The establishment of the social work business by Conservative governments and its modernisation by New Labour was an aspect of the undermining of much of the distinctive dynamic underpinning public services, as their former distinctiveness was collapsed into a quasi-business discourse, with an economic culture institutionalised in increasingly taken-for-granted meanings and behaviour. This economic culture has been built around a quasi-capitalist rationality, the embrace of the methods and culture of the capitalist sector, founded on the principles of efficiency, calculability, predictability and control by non-human technology (p.180).

'The culture of the capitalist sector' has been particularly evident in the privatisation of residential care for older people (discussed later in this chapter) which has seen care homes themselves treated as commodities and their residents regarded as either assets or liabilities (Drakeford, 2006; Scourfield, 2007a).

An important plank of the project of modernising (latterly referred to as 'transforming') adult social care has been the introduction of the 'personalisation' agenda (Department of Health, 2007). Consistent with ideas about the efficacy of markets, consumerism and individualisation, personalisation was constructed around the principle of using individualised funding schemes such as 'personal budgets' and the use of 'self-directed support' rather than directly provided care. In theory, the principle of personalisation should reach into care homes (SCIE, 2009), although, at the time of writing, little evidence is available to see how it has affected care home services for older people. However, since the turn of the century, several other important policy initiatives have been introduced into adult social care which have had significant implications for practice. For example, the publication of *No Secrets* (Department of Health, 2000b) placed the responsibility for the co-ordination of safeguarding adults with local authorities. The national and local profile of safeguarding vulnerable adults has steadily risen since the publication of *No Secrets* and, as a consequence, adult safeguarding work, together with work implementing personalisation now forms the bulk of statutory adult social care practice. However, many commentators (see, for example, Manthorpe *et al.*, 2011) have pointed to the complexities and potential conflicts in implementing the two agendas.

In 2001, the New Labour government published the *National Service Framework for Older People* (NSF) (Department of Health, 2001b), Lymbery (2005) explains its relevance to community and social work:

There are four general themes within the NSF, with eight standards being linked to these themes. The first broad theme is 'Respecting the Individual', and the two standards attached to it are both social work central concerns. Standard 1 is 'Rooting out age discrimination', and applies equally to health and social care



services. .... Standard 2 is 'Person-centred care', stressing that people should be treated as individuals and proposing a pattern of integrated service delivery, including single assessments, etc. Again, given the fact that social services departments are responsible for large numbers under community care, this standard is clearly central to social workers (p.75).

In addition to these major policy initiatives, New Labour also introduced the Mental Capacity Act 2005 which was fully implemented in October 2007 and provides a statutory framework to both empower and protect adults who lack, or may lack, capacity to make certain decisions for themselves because of illness, a learning disability, or mental health problems such as dementia. It brings with it a requirement to assess a person's mental 'capacity' in making critical decisions, for example, in relation to property, financial affairs, health care treatment as well as decisions about personal care.

The community care reforms of the 1980s and 1990s, therefore, began a process of considerable upheaval in the adult social care system, which has continued relentlessly through to present times. Over and above the original reforms, several major policy initiatives have been rolled out in this sector. Most recently, the emergence of safeguarding and personalisation (both of which have been underpinned by new legislation on mental capacity) represent a considerable challenge to those involved in delivering adult social care, not least because they have been implemented in an increasingly tight financial environment. Against this backdrop, the NSF has laid down expectations that service users will not be

discriminated against on ground of age and that they should be treated as individuals in a 'person-centred' manner.

### **Care management**

As outlined, various reforms have led to radical reorganisations in the way services are delivered and regulated; they have multiplied the number of actors involved in the process and, therefore, further dispersed power and responsibilities throughout the system. Yet, despite the multiplication of actors in the adult social care system, the chief responsibility for assessing eligibility for services has remained with the local authority 'care manager'.

Having been signalled in both the *Griffiths Report* (Griffiths, 1988) and *Caring for People* (Department of Health, 1989) the care manager role was created officially by introduction of the NHS and Community Care Act 1990 and outlined in subsequent official guidance (Department of Health, 1991a, 1991b; Lewis and Glennerster, 1996). It was more recently reinforced in *Modernising Social Services* (Department of Health, 1998). Care managers were to be central to how the system operated as they would be the front-line gatekeepers to the service. In the 1980s, influenced by care manager-brokerage models that existed in North America and elsewhere, different ideas of case-management/care-management were explored for the delivery of adult care services. During this period the *Personal Social Services Research Unit* (PSSRU) in partnership with local authorities undertook a number of demonstration studies (Challis and Davies, 1986; Challis *et al.*, 1995; Challis *et al.*, 1998a and 1998b; Payne, 1995). This research was designed so that it was particularly focused on cases of people with complex health and social care needs

and in a specific context where caseloads were small, involvement was long term, and budgets were devolved to care managers (Challis and Davies, 1986; Challis *et al.*, 1995). As Challis (1999) explains:

The model of care management that was developed in these schemes was designed to ensure that improved performance of the core tasks of care management could contribute towards more effective and efficient long-term care for highly vulnerable people (p.70).

The findings from these projects not only demonstrated successful outcomes for service users, they also indicated that these outcomes could be achieved at no increased cost to the public purse (Challis *et al.*, 2008). However, importantly, the extent to which the findings from the PSSRU research could simply be generalised and applied across *all* situations of older people requiring some form of care input needed to be qualified. As Challis (1999) explains:

The evidence could not be generalised to a broader application of the care management approach to less vulnerable individuals. Key elements associated with the outcomes demonstrated included differentiated response to need; appropriate targeting; devolution of budgets; continuity of involvement of care manager with service user and appropriate links with specialist health care expertise (p.71).

Therefore, it was apparent that the care/case management outcomes found needed to be seen in the specific context in which the research was undertaken (Challis *et*

al, 2008). However, drawing on the research from PSSRU and others, the

Department of Health:

..... produced quite detailed advice on care management (Department of Health, 1991a, 1991b), which is described as the process of tailoring services to individual needs. Seven core tasks are involved in arranging care for someone in need:

- The publication of information.
- Determining the level of assessment.
- Assessing need.
- Care planning.
- Implementing the care plan.
- Monitoring.
- Reviewing.

The last five stages are best seen as a cyclical process whereby needs are assessed, services are delivered in response to the identified needs, and the needs are then re-assessed, resulting in the possibility of a changed service response. In this way, reviewing can feed back into a re-assessment of the situation and the establishment of a new or revised care plan (Department of Health, 1991a, 1991b) (Cited in Sharkey, 2007:65).

Subsequent research by the PSSRU (for example, Bauld *et al.*, 2000; Challis *et al.*, 1995; 1998a and 1998b) supported by findings from *Social Services Inspections* (Challis 1999) indicated that, on implementation nationally from 1993 onwards, care management arrangements and outcomes varied in many important respects from

local authority to local authority. On the negative side, various issues became apparent. These included: confusion as to whether 'eligibility' concerned eligibility for assessment, services or care management; concern about quality, in so far as there was a lack of standardisation and differentiation of assessment according to need; there were problems with the identification of health problems; a lack of continuity of contact with the same care manager, although valued by service users, was rarely achieved - with most care manager involvement at the assessment stage and, related to this and particularly pertinent to this study, there was a lack of monitoring and review with care managers excessively focused upon assessment. As these researchers have pointed out (e.g. Bauld *et al.*, 2000 and Challis *et al.*, 1995; 1998a and 1998b), to some extent, some of these failings were continuations of previous, poorly performing 'social work' arrangements with older people - as outlined earlier by the references to Parsloe and Stevenson (1978); Rowlings (1981) and Bowl (1986). However, the most extensive 'before-after' study carried out by the PSSRU - the *Evaluating Community Care for Elderly People* project (Bauld *et al.*, 2000) was able to demonstrate where care management was having more positive outcomes for older people and their carers than was previously the case. This included better targeting of services on older people with more complex needs, maintaining those with high support needs at home for longer and older people with more complex needs were more likely to have a qualified social worker as their care manager.

Evaluations of care management have therefore shown a mixed picture in terms of the anticipated outcomes for older service users and carers. As outlined above, whilst there have been some clear positives in some areas, in other areas, care management has not produced significantly better outcomes than previous social

work arrangements. Also, from the 1990s onwards, a body of evidence emerged that indicated that, despite hopes that an individualised, empowering, 'exchange' model of assessment and care management would evolve (Smale and Tuson, 1993; Payne, 1995, Challis *et al.* 2001), in practice, largely in response to difficulties in coping with the volume of the work (Challis, 1999) and being subject to intensified managerial discipline and performance measures, care management largely developed into a set of computerised and bureaucratic 'tick box' procedures as several studies have shown (Carey, 2003; Dustin, 2007; Harris, 1998; Irving and Gertig, 1999; Lymbery, 1998, 2001; Lymbery and Butler, 2004; McDonald, 1999; Postle, 2001; 2002; Sharkey, 2007).

In this transformed work environment, whilst some traditional social work casework skills were needed, the required skill set for care managers included the use of management information systems as well as accounting and budgetary skills (Dustin, 2006). The proceduralisation and routinisation of care management reduced the need for care managers to possess a social work qualification (Lymbery, 2005). These developments represented a significant setback in attempts to raise the professional status of social work with older people, which historically had been weak in comparison to other branches of social work, such as with children and families. Commenting on the impact of the community care reforms, Lymbery (1998) declared:

The balance of power in social work with older people has shifted substantially in favour of increased managerial dominance over practice; this may lead to a re-evaluation of the qualifications and experience required to perform particular tasks and a shift away from the employment of 'professionally' qualified staff (p.875).

The combination of deskilling and intensified workloads as a consequence of performance management has seen the emergence of an increasingly demoralised and alienated workforce, often reflected in high staff turnover (Carey, 2003; 2009; Postle, 2001; 2002). The intensified exertion of managerial controls and performance indicators on the pace and nature of the work has, in several ways, contributed more towards the disempowerment rather than empowerment of service users (Harris and White, 2009). The possibilities of building effective relationships, for example, are much diminished (Irving and Gertig, 1999; Weinberg *et al.* 2003). Jones (2001) found that contact between practitioners and service users 'is more fleeting, more regulated and governed by the demands of forms which now shape much of the intervention' (p.553) and that care managers were 'pressed to be speedy in their assessments, limit the contact with the potential client and get in and out quickly' (*ibid*). Commenting on the intensification of work brought about by the imposition of performance management regimes in social services, Harris and Unwin (2009) state that:

There is little in performance management that intrinsically values or encourages social workers to improve the detail of their practice and there is a lack of meaning and fit between quantitative performance measures and what is valued by social workers in the qualitative content of their day-to-day work, as they do the best they can for service users (p.28).

Harris and Unwin suggest that one of the important things about their job that social workers value is 'maintaining a level of discretion within which they define as what counts as a high standard of performance' (p.28). However, they point out that the use of discretion by social work practitioners in managerialised and modernised social work organisations has become a 'field of conflict'. As indicated, many writers

have framed the care manager debate very much in terms of reduced 'discretion'. Dustin (2006) highlighted the 'unresolved' nature of the debate around what actually constitutes the legitimate use of discretion. She comments:

The introduction of care management was intended to reduce the discretion of 'street level bureaucrats' (Lipsky, 1980). Professionalism requires reflective practice, and reflective practice is valued in social work training. However, when caseloads are high and demands are excessive, the time to reflect is minimal. The issue of the legitimate use of discretion and professional judgement in care management seems unresolved (p.303).

In foregrounding Lipsky's idea of the 'street-level bureaucrat', Dustin provides a useful conceptual starting point from which to examine how care managers deal with putting numerous policy directives, which are often ambiguous and conflicting, into practice in a context where 'caseloads are high' and time is short. It suggests that the ways in which care manager practice is managed should also be examined. Chapter Three I will discuss the idea of street-level bureaucracy and its relevance to social work in more depth.

The focus of this study is specifically on the review element of the care manager role and the evidence shows that, under pressure of time and volume of work, the different stages of the care management process have received varied attention. As noted earlier, more time and effort is concentrated on the 'assessment' and 'care planning' parts of the process and less on the 'monitoring' and 'review' functions (Mandelstam, 1998; Weinberg *et al.*, 2003; Lymbery, 2005; McDonald, 2006). The context to this is that there is no explicit duty in legislation to carry out a care review (Mandelstam, 2009). However, the requirement for local authorities to review adult



service users' care provision is set out in official guidance (Department of Health, 1991a; 1991b; Department of Health, 2002b; Department of Health, 2010a). It is important to clarify that the guidance in question is only directed towards those care arrangements where the resident *receives some degree of local authority funding*. Self-funding residents of care homes are not covered, although care homes are required, by guidance, to conduct their own in-house reviews of their residents' care plans (Department of Health, 2003; CQC, 2010a; 2010b).

Mandelstam (1999) highlighted how local authority reviews have often been seen as 'rubber stamping exercises' (p.158). Nevertheless, despite their 'Cinderella' status, reviews fulfil a number of important purposes both for the person in receipt of services and the local authority. These include reviewing whether the care plan drawn up by the local authority continues to meet the service user's needs and revising the care plan accordingly (Department of Health, 1991a, p.85). However, reviews are also about ensuring that service users continue to meet the eligibility criteria. The latter purpose has meant that reviews have come to be associated with cost cutting, particularly since services can only be withdrawn following a review and, indeed, have often been used in this way (Mandelstam, 1998). Reviews, therefore, illustrate well how one event can involve the need for both managers and practitioners to resolve potentially conflicting agendas. This necessarily creates potential tensions for those responsible for carrying out reviews.

In many local authorities, both the drive for efficiencies and the need to hit performance targets, has led to divisions of labour within teams. Reviews are often carried out not by the care manager who had initially assessed the service user but

by a different worker (usually a member of a dedicated review team) (Bauld *et al.*, 2000). The need to conserve resources has also meant that reviews sometimes take place without the actual service user being present (*ibid*). This raises the obvious question of how care managers, under such conditions, can be expected to perform the 'professional' task set out for them in guidelines of reviewing the needs of vulnerable people in care homes.

## Summary

The current system of statutory care home reviews can be traced back to the community care reforms of the 1990s. These reforms marketised and privatised the adult social care system. The reforms also instigated a series of changes in the system of social care regulation. Both of these processes have led to a dispersal of power via the multiplication of actors involved in how social care is now 'delivered'. Building on these reforms, New Labour's programme of 'modernising' adult social care has brought with it major new initiatives such as personalisation and safeguarding as well the integration of health and social care services. These changes have all combined to intensify the challenges facing those working in the sector, not least care managers who are those chiefly responsible for putting policy into practice on the front-line. I have highlighted the tensions inherent in the care manager role and also highlighted the debate that exists about the extent to which practitioners are able to exercise discretion in resolving these tensions. In this context, I have made a link to this debate and the work of Lipsky (1980) concerning 'street-level bureaucracy' and that will be developed further in the next Chapter.

The specific focus of the study is on how older people funded by the local authority have their care home placements reviewed in accordance with community care legislation. Therefore, to further place this into context requires a discussion of the changing care home sector in which statutory care home reviews take place.

## Care Homes for Older People

### The Structure of the Care Home Market

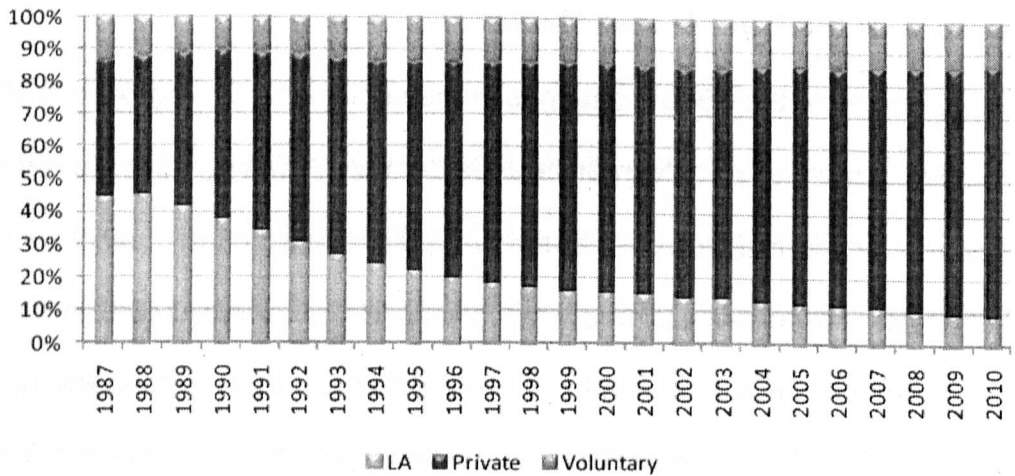
As discussed above, in the 1980s, changes in the social security regulations were made which allowed older people in private residential or nursing care homes to claim supplementary benefit to cover board and lodging expenses (Lewis and Glennerster, 1996; Means *et al.*, 2008). As Lewis and Glennerster (1996) stated:

What the government has done was to create an effective voucher scheme for old people and their families. Families chose the private facility and the government paid (p.4).

This policy quirk not only meant that there was a dramatic rise in social security expenditure from £10 million per annum in 1979 to £1872 million in 1991 (Johnson *et al.*, 2010b), it also created a 'perverse incentive' (Lewis and Glennerster, 1996) for older people to choose residential rather than domiciliary care to meet their needs. As a consequence, during the 1980s, the private care home sector began to grow significantly. As explained earlier, the community care reforms were introduced, largely, to contain the rising costs of residential care and promote home based care. However, they also helped change the structure of the care home market by promoting a purchaser-provider split with 85% of local authority 'transitional' funding to be spent on services from the independent sector (LASSL (92)). This was mainly

to help create a market for home care, however, as a consequence of various policy decisions in the 1980s and 1990s, the care home sector is now dominated by independent providers, the bulk of which are privately owned (see Figure 2:1).

**Figure 2:1**  
**Nursing and Residential Care Homes by Ownership Type, UK,1987-**



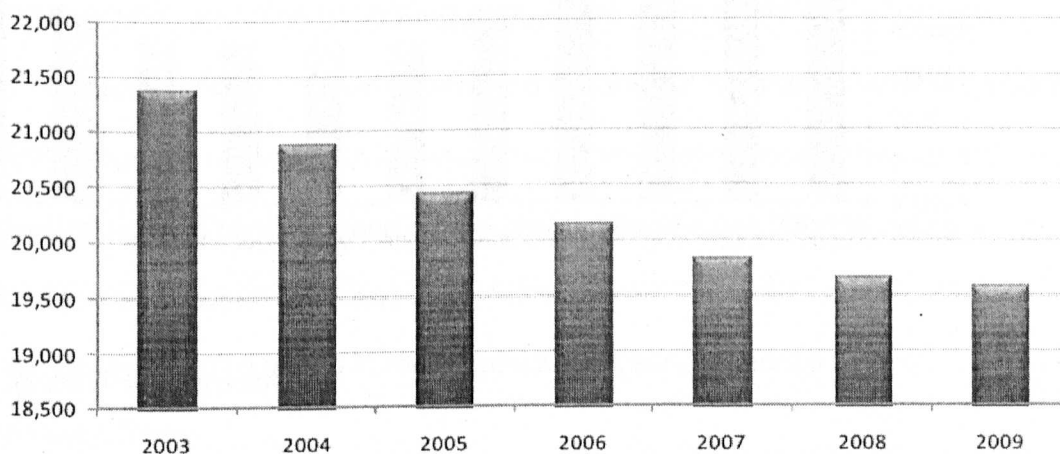
2010<sup>4</sup>

(Office of Fair Trading, 2011: 48)

During the 1990s and 2000s a combination of factors including reduced fees paid by local authorities to care homes on behalf of funded residents, rising costs of provision and the introduction of new regulatory regimes, particularly new *National Minimum Standards* (Department of Health, 2003) led to a period of decline in the overall number of care homes (Dalley *et al.*, 2004; CSCI, 2009; Help the Aged, 2007; Johnson, *et al.*, 2010a) see Fig 2:2.

<sup>4</sup> Part I, Section 3 of the Care Standards Act 2000 defines a care home as any home which provides accommodation together with nursing or personal care for any person who is or has been ill (including mental disorder), is disabled or infirm, or who has a past or present dependence on drugs or alcohol. As a consequence, there is no longer a sharp distinction between 'Nursing Homes' and 'Residential Care Homes'. What were called nursing homes are now more likely to be called 'Care Homes with Nursing' and Residential Care Homes simply 'Care Homes'.

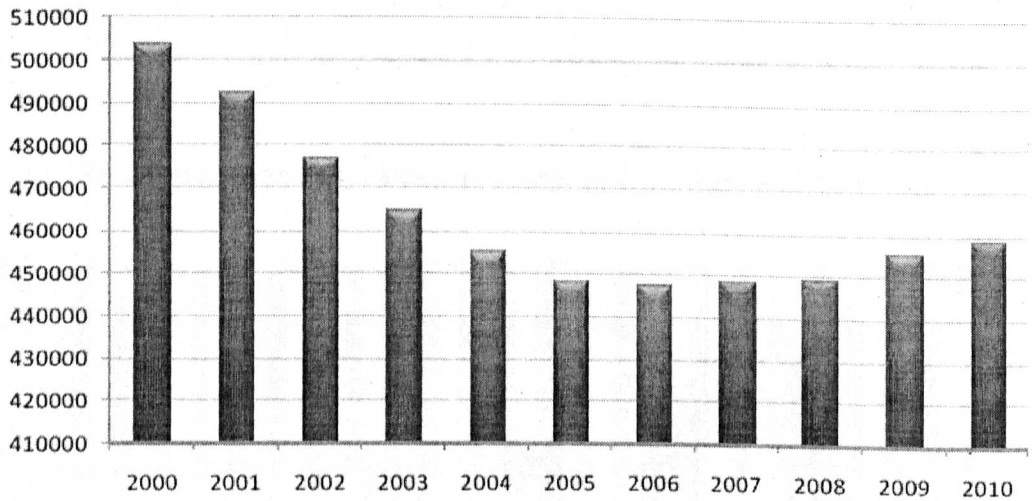
**Figure 2:2 Nursing and Residential Care Homes, UK, 2003-2009**



(Office of Fair Trading, 2011: 46)

However, largely driven by demographic factors and the unavailability of suitable community alternatives, it is expected that demand for care home places will expand over the next decade (Laing & Buisson, 2009). The rise in the number of care home places since 2006 (see Fig. 2.3) together with the decrease in the number of homes over the same period (see Fig. 2.2) reflects the trend towards larger care homes in recent years.

**Fig. 2:3 Nursing and Residential Care Places, UK, 2000-2010**



(Office of Fair Trading, 2011: 47)

The challenging market conditions throughout the last decade have helped concentrate ownership of much of the sector into a decreasing number of large private chains. This has provoked some concern about the consequences for 'the consumer' (residents *and* local authorities) of increased provider power, in terms of weakened security, reduced choice and a general blurring of accountability (Drakeford, 2006; Scourfield, 2007a). Economic factors are also largely behind the trend towards larger care homes (Laing and Buisson, 2010) which raises the possibility of diminished care quality (Drakeford, 2006).

### **An overview of the care home market for older people in 2011**

In 2011 the Office of Fair Trading (OFT) evaluated the impact of its 2005 market study in older people's care homes (OFT, 2011) and found that there had been

some improvements for the 'consumer' in terms of how the care home market operated. For example, better complaints procedures were in place, more residents were either issued with contracts or with clear terms and conditions, there was improved transparency on pricing and both the quality and quantity of information available to consumers about care homes was better. However, the OFT argued that there was room for improvement in raising consumer awareness about any information available and also in helping consumers to evaluate any information once they had accessed it. The OFT identify a number of changes in the five years since its 2005 study. In terms of the *demand* for care home places, they found that:

- the level of demand for care home places has stabilised since 2005 following a steady reduction between 1993 and 2005
- this stability in overall demand in recent years has been influenced by two countervailing forces:
  - the ageing population and rising levels of disability and dependency among older people has increased demand for care home places
  - the growth in domiciliary care and 'rationing' by local authorities via more restricted use of eligibility criteria has pushed down the demand for care home places
- there has been a change in the composition of the care homes population with more self-funders and fewer local authority-funded residents which, *prima facie*, increases the opportunities for cross-subsidisation by care home providers
- the increasing complexity of needs among the over 65s (most notably the increase in the proportion of the population aged 85 years or more and the growth in those diagnosed with dementia) suggests an older and frailer population entering care homes, and
- the process by which people decide on a care home does not appear to have changed significantly although the increased frailty and healthcare needs of those

entering care homes suggests a greater dependency upon family and friends in the decision-making process surrounding future care arrangements and greater pressure to make decisions more quickly and without foresight or planning (OFT, 2011: 45).

In terms of the *supply* of care home places, the OFT study highlighted a number of changes over the previous five years, which were that:

- the number of care homes has fallen since 2005 but overall capacity in 2010 is higher than that seen in 2005
- a growing consolidation within the market for care homes with a number of smaller residential care homes being replaced by fewer, larger nursing homes
- a rise in the average places per care home over the last five years
- stability in overall care homes capacity is consistent with stability in overall levels of demand for care homes
- supply is not uniform across the UK. The North East has the highest number of care home places per 1,000 population aged 65+ and is the only region which saw an increase in provision relative to population levels since 2005 and
- private providers continue to contribute most of the supply in the market, with third sector and local authority providers supplying the remainder, a pattern which has not changed since 2005 (OFT, 2011:46).

Part of the OFT's overall conclusion strongly echoed the points made earlier in this Chapter about the fragmentation of the adult social care sector and the multiplication of actors in it, which has led to power being more widely dispersed throughout the system (Clarke, 2004). This is when the OFT concludes:

Quantifying the full costs associated with implementing the OFT study's recommendations is made extremely challenging by the multiplicity of different agents responsible for driving change within the sector. Given the fragmented nature



of the sector, the different rates of progress in terms of responding to the OFT's recommendations and the lack of sound data on the costs of implementing the recommendations, we are unable to quantify with any certainty the full costs associated with implementing the OFT's recommendations across the market (OFT, 2011; 12).

The situation described by the OFT underlines, firstly, how, despite some improvements, 'consumers' in the care home market cannot be wholly confident about either the quality or value for money of the care they purchase or have purchased for them and, secondly, that 'the multiplicity of different agents responsible for driving change' can only complicate already blurred lines of accountability.

### **The older care home population**

Whilst the care home sector has undergone significant changes in terms of its size and structure since the 1980s, the characteristics of the care home population have also changed significantly over this time – largely as a direct consequence of policies introduced which have focused on keeping frail older people at home longer. Therefore, not only is the average age of the care home population higher, but levels of dependency are greater and needs more complex than in previous decades (Bowman *et al.*, 2004; Netten, *et al.*, 2011; Help the Aged, 2007, OFT, 2011). In 2004, there were estimated to be around 410,000 older people living in care homes across the UK (OFT, 2005). The Office of Fair Trading (2005) found that:

...most care home residents are over 85 years old. Female care home residents tended to be older than male residents, at an average age of 85.6 years for women

compared to 83.2 years for men. Women are also more likely than men to be severely disabled, although a high proportion of both sexes have health problems; 75 per cent of all care home residents are severely disabled (p.21).

Bebbington *et al.* (2001, cited in Help the Aged, 2007) found that dementia was the most common illness associated with admission to a care home. This was reported in about 38 per cent of residents. The Department of Health (2008) claimed that:

..... over 200,000 people with dementia live in care homes, which represents around one third of all people with dementia (p.90).

The changing profile of the care home population clearly has many implications, for example, in terms of specialist training and facilities, but also for the ability of residents to act as authentic 'consumers' (Clarke and Newman, 1997). The ambiguous power relations that exist between carer (both formal and informal) and 'cared for' in care homes makes exercising the right to complain problematic (Burgner, 1996; OFT, 2005; Help the Aged, 2007).

There have been other noticeable changes in the care home sector, for example, in how the older care home population is financed. The majority of the care home population is still funded, in some degree, by their local authority (OFT, 2011; SCIE, 2011). According to SCIE (2011, p.11), 'about a quarter' of local-authority funded placements are topped up by third party payments (mostly from relatives) where a short fall exists between the local authority's baseline fee and what the care home actually charges. The proportion of fully self-funding residents is steadily increasing,

although the exact number of self-funders is difficult to determine (SCIE, 2011). By 2009, Laing and Buisson (2009) estimated that 41% of care home places for older and physically disabled people in the UK were fully self-funded, equivalent to £5.4 billion of the total care home market of £13.2 billion (SCIE, 2011: 11).

This increase is largely attributable to the rising value of house prices and the relatively low threshold set by local authorities for a resident to become fully responsible for fees. The co-existence of local authority funded and self-funded residents in care homes has brought to the surface several issues of equity. These have focused, for example, around different levels of guidance provided and the fact that, in many homes, self-funders effectively cross subsidise local authority funded residents (Wright, 2003; Dalley and Mandelstam, 2009; Scourfield, 2010; SCIE, 2011). The ramifications of this situation are complex, not least in respect of a likely sense of injustice experienced by self-funders and their relatives and the possibility of stigma felt by local authority-funded residents and their relatives.

## **Care home standards**

What constitutes quality of care in care homes and how, once established, standards of care should be regulated, has been the subject of intense debate over the last fifty years. The succession of new regulatory regimes has brought some improvements in the sector with more standards being met (CSCI, 2009). However, poor institutional practices persist in some homes. These include; lack of privacy, lack of choice, lack of dignity and the failure to treat older residents as individuals, as well as variable quality of the physical environment. (For an account of how these issues have been raised

and dealt with over the decades see; Townsend, 1962, Department of Health and Social Security, 1981; Centre for Policy on Ageing 1984; 1996; Audit Commission, 1985; Willcocks *et al.*, 1987; Wagner, 1988; Dalley *et al.*, 2004; OFT, 2005; Help the Aged, 2006; CSCI, 2009). The reasons are complex and, arguably, reflect dimensions of ageism in wider society (Age Concern, 2006; Open University and Help the Aged, 2007).

The care home sector is characterised by low levels of funding (Help the Aged, 2007). A report by the UK's biggest 'not for profit' care home operator, BUPA (2011), stated that fees paid by local authorities and the NHS are typically below 'fair fee' levels, claiming that:

Since they took on the lead role in purchasing state-paid care from 1993, local authorities have tended to use their purchasing power to set fee rates which are lower than 'fair price' levels. This has left a 17-year legacy of under-funding in the care home sector. Evidence for this comes from surveys of baseline fee rates (the rates that councils are usually willing to pay) set by local authorities....it is possible, however, to conclude from published information on baseline fee rates that very few local authorities pay at a fair level – as defined by the Fair Price Toolkit developed by Laing & Buisson in association with the Joseph Rowntree Foundation (p.6).

The low 'baseline fee rates' paid by local authorities has had a negative impact on care homes which rely on this form of funding. In extreme cases, it has contributed to care home closures (BUPA, 2011). Furthermore, the downward pressure on the wages paid to care home staff has been linked to poor quality of care (Royal College of Nursing, 2011). Low wages have also contributed to high staff turnover which is a

chronic problem in the care home sector. Over 40% of care home staff left their jobs within their first year and 60% left within two years (Nursing Times, 2008). Much of the care home sector is characterised by low staff-resident ratios meaning that whilst, basic physical care needs might be met, many residents may be socially isolated within the home as well as being cut off from the rest of society (Nolan *et al.*, 2001). In this respect, Tester (2004) found little was done to facilitate key relationships; between residents, between staff and residents or between residents and relatives (see Clarke and Bright, 2006; Davies and Nolan, 2003, 2004, 2006 and Edge, 2008; for a fuller discussion of the issues faced and role played by relatives of older people admitted to care homes).

More recently, evidence has emerged to show that standards of medical care for older people in care homes are inadequate (Older People's Specialists' Forum, 2010). Specifically in respect of dementia care, the National Audit Office (2010) found that the quality of care varies. The report states:

Recent research reveals that 70 per cent of care home residents experience drug errors caused by poor staff training. And an independent review, which had been commissioned by the Department reported in November 2009 that up to 150,000 people with dementia are inappropriately prescribed anti-psychotic drugs, contrary to clinical guidelines (p.18).

There has also been concern expressed about how care homes deal with end-of-life care (Katz and Peace, 2003; Froggatt, 2005; Badger *et al.*, 2007). It was reported in 2008 that, while roughly 17% of older people die in a care home, much end of life care

in care homes is 'suboptimal' (Department of Health, 2008). Lastly, it has been increasingly recognized in recent years that care homes can be the site of different forms of abuse (Glendenning and Kingston, 1999; Department of Health, 2000; Action on Elder Abuse, 2010). The powerlessness of many care home residents continues to be left unaddressed and raises critical questions about how well residents' rights, not only as consumers but also as citizens, are protected (Scourfield, 2007b). It should be stated, however, that the quality of care in care homes varies considerably across the sector, with the quality in the best performing homes (often smaller in size) being more than satisfactory (OFT, 2005). Nevertheless, evidently, there remain deeply embedded problems in the care home sector that present significant challenges to those tasked with ensuring standards of care are maintained, residents are safeguarded and their rights upheld.

## **Summary**

I have explained how, since the introduction of the community care reforms in the 1990s, the number of care homes for older people has decreased, that care homes are getting larger and that the majority of care homes are now privately owned. I have also explained how the older care home population has changed over this period. For example, whilst the overall care home population has decreased in numerical terms since 1990, this population is now more likely to be, on average, significantly older than in previous decades and have more complex needs which would include significant cognitive impairment. It has also been discussed how the proportion of older care home residents fully funded by their local authority has been decreasing, with a rise in the number of 'third-party top up' arrangements amongst those who are local-authority funded. Lastly, I have highlighted that the care home sector has

undergone several changes of regulatory regime since the 1990s, but despite the introduction of various quality controls the quality of care in some care homes continues to be criticised for a range of reasons, not least of which is the effect of low baseline rates paid by local authorities. Overall, I have highlighted that there are various, interrelated, factors that make the challenges facing those reviewing the care arrangements of the older care home population both more complex and more intense.

### **Situating the study locally: key characteristics of the field**

## **Older people in the County**

The local authority (hereafter known as 'the County') in which the study took place is a shire county with a population around 600,000. According to statistics available in the County's Joint Strategic Needs Assessment (JSNA)<sup>5</sup>, in 2009, there were an estimated 92,680 people aged 65 or over (16% of the total population), over 43,000 people aged 75 or over (7%) and 11,500 people aged 85 or over (2%). These percentages are in line with national averages. People aged 65+ made up 69% of all adult clients of social services (Local Authority/NHS, 2009). In 2009, there were estimated to be 13,900 older people in the local authority area who were physically or mentally frail or both (Local Authority/NHS, 2009). The number of people with dementia was predicted to rise from approximately 6,580 in 2006 to 10,240 in 2021, which broadly reflects the national picture (Alzheimers Society, 2007).

## **Care homes in the County**

In 2006 at the time when the study commenced, according to the then care regulator (the Commission for Social Care Inspection), there were a total of 68 registered homes. Of these 57 were privately run and 11 run by different voluntary organisations. Fifty eight were registered as 'care homes only' and 10 were registered as 'care homes with nursing', nine of which were privately run.

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<sup>5</sup> A Joint Strategic Needs Assessment (JSNA) is the means by which Primary Care Trusts and local authorities describe the future health, care and wellbeing needs of the local populations and to identify the strategic direction of service delivery to meet those needs.



When the study commenced in 2006, the total number of nursing and residential beds in care homes available for older people was 3,384. Of these, 1480 were 'council supported' (National Statistics, 2006). However, by 2009 this figure had fallen; 1282 were supported financially by the local authority partly because of policies to keep older people at home as far as possible (Local Authority/NHS, 2010). The 'benchmark' fee paid by the local authority was £375 per week for residential care home beds, £463 per week for a dementia care bed and £552 for a nursing care bed. These levels were slightly below the national average (Laing and Buisson, 2008). A more detailed profile of the homes in which reviews were observed can be found in Appendix 4.

### **Locality teams and care home reviews in the County**

Statutory care home reviews took place as part of the broader system of adult social care in the County. Social care services in the County were accessed via one of 13 integrated 'locality' teams. Under the overall management of a 'locality team manager', as well as health professionals such as physiotherapists and occupational therapists, each team contained social care staff responsible for care management including assessment and review functions. The number of care managers varied in each team but typically ranged between four and six and not all possessed professional care qualifications, social work or otherwise. It was common for care managers not to hold a professional social work qualification but to have gained relevant vocational experience by working in different care settings, including care homes, during which time some would have studied for relevant NVQs. Locality team managers were likely to have either health or social care backgrounds.

It was not possible to find accurate, disaggregated data on the number of care home reviews of older people carried out annually in the County. Locally held data combined domiciliary and non-domiciliary reviews of services to people 'over 65'. However, considering that the County was working to guidelines that required care home placements to be reviewed at least annually and given the number of local authority funded residents, it can be assumed that the target number of reviews would have been somewhere around 1200 (in 2009) and 1400 (in 2006) care home reviews per year.

### **Organisational changes**

As discussed earlier in this Chapter, the 'modernisation' agenda in social care led to a range of policy initiatives, one that had a far reaching impact on the County was the directive that local health and social care services should be integrated in order to provide a more 'joined up' service (see NHS Plan (Department of Health, 2000a) for background). As a consequence, in 2004 the County social care services began a major restructuring exercise, which was to become the first of many in response to both national and local agendas linked to modernisation and related policies. As far as older people's services were concerned, in 2004 what were distinct local authority-run social services teams became 'integrated' health and social teams falling within the organisational structures of the local Primary Care Trusts (PCTs). This process included the transfer of Social Services staff to the PCTs. The impact of this radical change was made more difficult because it took place in the context of financial difficulties.

Within two years (in 2006) another major restructuring had taken place. This time, more for reasons of efficiency, locality teams were reorganised into 'business units' which were no longer under the direct control of the PCTs. Also in 2006, the regulator (CSCI at that time) required that further changes be made to the way that the County delivered social care. Following an inspection of social care services, CSCI reported that the County was 'coasting' and highlighted the 'need for significant areas of improvement' in adult social care services. This required the County to produce an 'improvement plan'. As part of this plan, the following year (2007) another internal reorganisation, aimed more specifically at management levels was carried out. At the same time, having run up a deficit of over £50 million in 2007, the PCT were subject to a tight financial control programme called 'Turnaround' (Audit Commission, 2007: 2), which, amongst other things, had the effect of reducing resources, including staffing levels, across the board. The most recent major reorganisation came in April 2009 when adult social care functions were, once again, largely separated from the PCT and became 'community and adult services'. As with the other reorganisations this structural change led to locality teams being reconstituted within new management structures.

So many radical organisational changes in the County, occurring over such a short space of time affected the conduct of care home reviews because of changes in staffing and the associated uncertainty created about job roles and workloads amongst managers and practitioners. From my perspective, it also created difficulty in keeping up to date with organisational structures, roles and responsibilities. I discuss critically the full effects of this in Chapter Nine.

## Conclusion

In this chapter I have situated the system of statutory care home reviews for older people in their policy and practice context at both the national and local level. The literature on community care, care homes and older people in the care system is both broad and diverse. Therefore, this review has, necessarily, been selective in order to provide sufficient context but also to focus on the key themes relevant to this study. However, the discussion has demonstrated certain key points. First, the community care system is founded as much on the principles of securing value for money and rationing resources as it is about meeting need, secondly, 'community care' continues to evolve and represents the accumulation of several agendas; that the processes of marketisation, privatisation and modernisation have led to a multiplication of actors in adult social care and that this has led to a greater 'dispersal' of power, amongst, for example, commissioners, providers and regulators. Fourthly, the process of managerialisation has led to a debate about the extent to which practitioners are able to exercise their professional discretion under these conditions. In addition, I have highlighted how the needs of the older care population have become more complex at a time when, despite undergoing several changes, the regulation of care homes has come under attack for failing to adequately protect the interests of older care home residents. I have also explained how the care system nationally has continued to be the subject of major policy initiatives, some of which have led to significant organisational restructuring at the local level. As a consequence, practitioners and managers have had to absorb, implement and balance various, often conflicting, agendas whilst working in a context of continual policy change and uncertainty over job roles and responsibilities.

Overall, I have painted a picture of a system where the numerous challenges and conflicts facing its various stakeholders – chiefly, social care managers, practitioners and providers - have both intensified and become more complex over time, partly because of frequently changing parameters and demands. These challenges have, inevitably, created tensions in how potentially conflicting agendas are resolved. In Chapter Three I discuss how the idea of 'street-level bureaucracy' developed by Lipsky (1980) provides a useful starting point in understanding how discretion is exercised and the tensions created by the challenges outlined above are resolved. In Chapter Three I also discuss how review practice takes place in a policy context where the principle of facilitating service-user involvement has become prominent, thereby adding to the challenges to practitioners face.

## **Chapter Three: Street-Level Bureaucracy, discretion and the participation of older service users.**

### **Introduction**

In Chapter Two, I discussed how 'review' is an important but often overlooked element of the care management process and that the care manager role is significantly constrained by bureaucratic imperatives and financial controls. However, I also explained that official guidance on care management requires that service users' needs are met and I concluded that the need to balance divergent agendas created tensions in the system. I cited Dustin (2006) to introduce the idea of care managers as 'street-level bureaucrats' and claimed that the ways in which care managers use their discretion to deal with the tensions in the role make it a highly relevant area for enquiry in this study.

This chapter starts by discussing both the origins and key concepts that form the basis of the 'theory' of 'street-level bureaucracy'. This foregrounds the centrality of the concept of 'discretion' to the discussion. A distinction is made between '*de jure*' and '*de facto*' discretion in this context. It then moves on to discuss how 'street-level bureaucracy' has become widely adopted as a useful lens through which to investigate many areas of public service provision, including adult social work in the UK. The discussion also highlights how, as the context of public services has changed, the original thesis proposed by Lipsky (1980) has attracted various critiques. One particular critique concerns the assumptions he makes about the role played by management in organisations where street-level bureaucracy operates

and this is discussed in more detail. Another critique concerns the relatively scant attention Lipsky pays to the service user's perspective. The idea of service user involvement has become deeply embedded in contemporary discourses on public services in the UK. I raise the question of whether, in this discursive context, Lipsky's thesis also requires some modification in order to embrace this perspective, particularly given that one of my research objectives is to examine the role played by the older person in his or her own review. The chapter concludes by arguing that, with certain modifications, the concept of 'street-level bureaucracy' could continue to be a useful tool with which to understand the use of discretion in how policy is implemented in care home reviews.

### **Street-level Bureaucrats**

Lipsky's ideas about what 'street-level bureaucracy' is and how it works were originally proposed in a conference paper in 1969 (*ibid*: 213). He claims they were 'grounded in observations of the collective behaviour of public service organisations' (Lipsky, 1980: xi). The fully developed 'theory' was first published in the seminal text *Street-level Bureaucracy: The Dilemmas of Individuals in Public Service* in 1980 (Lipsky, 1980). Although derived from the context of urban politics in North America in the late 1960s and 1970s, the concept of street-level bureaucracy continues to make an influential contribution to the analysis of public policy across many areas of service provision in different countries (Hyde and Shafritz, 2008). For the purposes of this discussion, the concept can be broadly encapsulated by three key insights Lipsky makes about street-level bureaucrats (front-line workers) in public service organisations. The first is that:

...the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out (1980: xii).

Therefore, in contrast to traditional theoretical/structural 'top down' studies of how the policy process works, Lipsky develops a more empirically based and 'bottom up' approach which focuses more on the roles played by actors in public organisations in policy implementation (Hill, 2009). For Lipsky, policy is made reality at the micro-level, through the encounters between citizen and front-line worker. Speaking in 2010 Lipsky explained that street-level bureaucrats are:

....the people who meet citizens at the interface between citizens and government, so the police officer, the teacher, the social worker are the people who actually deliver the policy that has been constructed elsewhere. Those people are very important to the citizen because whatever they get from government is what the street-level bureaucrat actually does with them (Lipsky, 2010).

Given that the aim of my research is to understand how the care home review system works at the micro level, particularly from the point of view of the 'citizen', this is an important insight suggesting that Lipsky's work is very relevant to this study.

The second important insight Lipsky makes is that:

Street-level bureaucrats work with inadequate resources in circumstances where the demand will always increase to meet the supply of services. Thus they can never be free from the implications of significant constraints. Within these constraints they have broad discretion with respect to the utilization of resources (by definition). In the



application of resources to the job they confront the uncertainty that stems from the conflicting or ambiguous goals that unevenly guide their work. (1980:81).

The key point about this insight comes from the fact that street-level bureaucrats have to implement 'conflicting or ambiguous' policy agendas under conditions of 'inadequate resources'. This, inevitably, presents them with dilemmas that need to be reconciled on a daily basis. Therefore, in this work environment, the various conflicting and ambiguous policy and organisational goals become the source of dilemmas in practice, rather than the key to resolving them. Therefore, critically, street-level bureaucrats must use the 'broad discretion' available to them to reconcile the dilemmas that inevitably emerge. Chapter Two explained the challenges facing local authority social care teams in implementing multiple, ambiguous and, at times, conflicting agendas in a context where care home residents' needs have become more complex and public resources are diminishing. They are expected to deliver a service that is 'needs-led', offers 'choice' and is 'person-centred' (all ambiguous goals) under conditions of scarce resources and with the need to meet performance targets. The second insight highlighted, therefore, underscores the relevance of Lipsky in drawing our attention to the fact that the exercise of a significant degree of discretion is required in resolving these challenges or 'dilemmas' in practice.

The third key insight Lipsky makes, follows on from the point made above in that the consequence of having discretion is problematic psychologically for street-level bureaucrats because as Lipsky (1980) explains:

Their work involves the built-in contradiction that, while expected to exercise discretion in response to individuals and individual cases, in practice they must process people in terms of routines, stereotypes, and other mechanisms that facilitate work tasks (p.140).

Therefore, one of the ways of making the job of street-level bureaucrats easier to manage is to develop a 'client-processing mentality' using various strategies and mechanisms to reduce the tensions inherent in the job role. Lipsky argues that:

First, street-level bureaucrats modify their objectives to match better their ability to perform. Second, they mentally discount their clientele so as to reduce the tension resulting from their inability to deal with citizens according to ideal service models (p.141).

Lipsky identifies a range of strategies with which street-level bureaucrats exercise the discretion available to them in order to make their job manageable. These include: rationing services by restricting the use of time and information; controlling clients and the work situation by structuring interviews in ways that constrain what clients want to say and collecting information in a format that would meet 'bureaucratic success criteria' (p.107). Another way in which street-level bureaucrats survive psychologically is, according to Lipsky, not to quit the job, but to 'withdraw psychologically' through, for example, absenteeism, rejection of personal responsibility or just slowing down.

It is important to clarify that Lipsky is not arguing that street-level bureaucracy should simply be seen as being about the deliberate and cynical attempt by front line workers to do the minimum of work at every available opportunity.

As Lipsky explains:

Street-level bureaucrats often spend their work lives in a corrupted world of service.

They believe themselves to be doing the best they can under adverse circumstances, and they develop techniques to salvage service and decision-making values within the limits imposed upon them by the structure of the work (1980: xiii).

Lipsky, therefore, argues that street-level bureaucrats do not necessarily set out to deny rights of entitlement to service users or to cut corners. However, due to the 'conflicting or ambiguous goals that unevenly guide their work' they are seldom able to attain the service ideal as set out in policy. Using the discretion available to them, street-level bureaucrats necessarily *have to* compromise. Therefore, they adopt a range of work limiting strategies and short cuts. However, because street-level bureaucrats often enter public service with 'professional orientations', the short cuts they, knowingly, take to help make both the job bearable and the work manageable have to be rationalised as 'inevitable' because:

Taking limitations in the work as a fixed reality rather than a problem with which to grapple, street-level bureaucrats forge a way to obtain job satisfaction and consistency between aspirations and perceived capability (p.144).

Lipsky therefore suggests that, when faced with ambiguous and conflicting goals and inadequate resources to meet demand, street-level bureaucrats manipulate their clients, their work situation and their concept of what they are doing. They are able to do this because the nature of their work is always sufficiently complex to require human intervention and is usually carried out unsupervised in face-to-face situations with clients. This, therefore, provides street-level bureaucrats with the opportunities

to use their discretion in adopting the various strategies outlined. This insight from Lipsky suggests that attention needs to be paid to understanding what compromises are made, why and how they are made.

In the early 2000s, Evans (2010a) used a case study design to examine critically 'Lipsky's street-level bureaucracy perspective in relation to professional discretion in managerialised Social Services' (p.71). He based the study on two adult social care teams, one mental health and one for older people. Evans' work informs a significant part of this Chapter and, as far as the relevance of considering discretion, he concludes:

...discretion is not only inevitable but also necessary in welfare bureaucracies. Public service organisations are necessarily complex and unwieldy bodies with vague and conflicting policy goals and limited resources. Discretion arises from the need to turn broad goals into practical policy, and to decide how to use limited resources to achieve those goals (p.3).

Evans, therefore, underlines the fact that public services cannot actually function *without* discretion. The more complex the organisation, the more vague and conflicting its policy goals, the more important and pragmatic role discretion plays in turning broad policy into practice.

This summary of 'street-level bureaucracy' as set out by Lipsky (1980) has, necessarily, been selective in its focus. However, it does identify its key precepts and, by reference to more detailed analyses (for example Evans 2010a and 2010b),

I have demonstrated its enduring suitability as a conceptual framework with which to study contemporary local authority social services.

## **Lipsky applied to social services**

The local authority social services departments created in Britain in the 1970s were 'bureau-professional regimes' (Clarke and Newman, 1997, p.62 *passim*). Evans (2010a) explains that, in this context, 'bureau-professionalism':

... refers to the combination of organising principles of bureaucracy and professionalism in Social Services Departments during the first decades following their establishment in the wake of the Seebohm report. Social Services, while located within the bureaucratic structure of local authorities, were strongly influenced by professional principles of the organisation, emphasising professional supervisors as supportive colleagues rather than directive managers, and professional staff operating with a significant degree of discretion, trusted by fellow professionals who occupied the significant hierarchical posts within Social Services as an organisation (p.49)

Therefore, social work has never been a profession in the same way as the more established professions such as medicine or law which are based around notions of the independent and self-regulating professional (Clarke and Newman, 1997). These professions exercise discretion in a way that Evans (2010a) describes as '*de jure*' because it is about having the 'power to decide as an officially recognised entitlement' (p.33). However, whilst it has its own professional body (BASW) and has adopted professional codes and values, statutory social work has always taken place in the context of statutory duties, bureaucratic structures and organisational rules which have reduced, if not eliminated, the possibility for autonomous

professional judgement. As a consequence, White (2009) has described social work as a 'state-mediated profession' (p. 131), elaborating that:

Social workers have, then, been regarded as state-mediated professionals who have a degree of 'technical autonomy' (discretion) over the *means* by which they carry out the *ends* of the state, within a professional treatment model (p.133) [original italics].

In this 'bureau-professional' or state-mediated' context, the form of discretion exercised is not '*de jure*', it is '*de facto*' in the sense that it is about having a degree of freedom within the job role 'to make a choice among possible courses of action or inaction' (Evans, 2010a: 33).

Following their establishment in 1970, local authority social services departments in the UK led to an expansion of the social work 'profession' whose 'professional' role was to use discretion to enact relevant policy and legislation (Harris and Unwin, 2009). However, as discussed in Chapter Two, from the 1980s onwards, social services have been subjected to processes of managerialism. The impact of managerialism on bureau-professionalism in statutory social services over subsequent decades has provided the context, for many academic studies both in the UK and in other countries. Several have chosen to use the lens of 'street-level bureaucracy' through which to examine the extent to which managerialism has 'squeezed out' different forms of 'professional' discretion (see, for example, Hill, 1982; Howe, 1991; Cheetham, 1993; Lewis and Glennerster, 1996; Ellis *et al.*, 1999; Bain and Taylor, 2000; Baldwin, 2000; Bovens and Zouridis, Postle, 2001; 2002;

Evans and Harris, 2004; Dunér, and Nordström, 2006 (Swedish study); Ellis, 2007, 2011; Harris and White, 2009; Evans, 2010a and 2010b).

Earlier commentators have proposed that, in the wake of the managerial reforms that have transformed social work, the discretionary space allowed to front-line workers has been substantially squeezed out and consequently, the relevance of Lipsky has been greatly diminished (Howe, 1991; Cheetham, 1993). Howe's argument was that:

Except in *matters of style*, [my italics] all the substantive elements of their work are determined by others, either directly in the form of managerial command or indirectly through the distribution of resources, departmental policies and procedures, and ultimately the framework of statutes and legislation that create both welfare clients and welfare agencies (1991: 204).

Those who believed that social work practice was still firmly in the control of the 'social work profession', were, Howe suggested, given a 'clever boost' (p.203) by the concept of street-level bureaucracy because it turned on the concept of practitioner discretion. So he posited that the increased managerial discipline exercised over social work practice meant that the era of street-level bureaucrat discretion, as conceived by Lipsky, was basically over. As he noted:

Less and less is the social work practitioner able to interpret situations in the light of her own professional knowledge and experience. As the amount of 'technicality' increases in her job, so the area of 'indeterminacy' decreases (p.217).

Like Howe, Ellis *et al.* (1999) also concluded that front-line workers' discretion was being 'squeezed out' by greater management controls (p. 276). In this case, the

authors claimed that processes of managerialisation were reinforced by the 'application of new technology' (ICT). For example:

Social workers' actions were shaped by the completion of a series of computer screens based on formal priorities during the initial stages of assessment (*ibid*).

The transformative impact of ICT has not been insubstantial. However, whether its disciplinary effects are all-encompassing is open to debate. For, Bovens and Zouridis (2002) not only has ICT contributed to the routinisation of front-line practice but it has helped make it more transparent and accountable. They assert that:

Knowledge-management systems and digital decision trees have strongly reduced the scope of administrative discretion (2002: 177).

The key word here is 'reduce' rather than 'eliminate' because the capacity for workers to resist the managerial or organisational control through ICT should not be underestimated (Bain and Taylor, 2000).

In her 1997 study of two social work teams working with older people undergoing change, Postle (2001) found that the introduction of ICT into social work was one of many factors that was causing tensions and demoralising newly created 'care managers' in the wake of the community care reforms. She paints a bleak picture of demoralised and confused care managers facing the challenges of trying to do traditional adult social work in an increasingly managerialised environment. She found some resistance to the proceduralisation that accompanied care management, but concluded that:



Overall, it became apparent that, however much care managers resisted changes in their work, even to the extent of describing, as one of them did, the interpersonal aspects of it as undercover work, outside forces, driven by the market, were forcing changes and making it harder for care managers to resist them (p.21)

However, too much 'resistance' to managerialism exacerbated the tensions of the job and Postle found considerable evidence to support Lipsky's ideas about street-level bureaucrats adopting a client-processing mentality in order to manage the psychological tensions of having to ration resources in a public service role. For example:

A small number of staff coped with the work in a way which no longer involved questioning its inherent dissonances. This embodies a client-processing mentality by which people psychologically adapt themselves to their jobs in order to cope with its dissonances (p.20).

It appeared that, despite their 'professional' backgrounds, some staff adopted bureaucratic and procedural modes of working relatively unquestioningly. Postle also found that going along with the 'managerial grain' was easier for some care managers than others. Quoting one care manager Postle states:

Despite their stated dislike of procedural approaches, some care managers, such as the one quoted here, appeared to be 'client-processing':

*I just think I'm a DSS officer and I'm a bureaucrat . . . probably a bit more compassionate ... (Duty is) front line and my aim is to get rid of as many referrals as possible . . . try to divert them somewhere else before I even have to deal with them ... Get rid of it, that's my aim (p.20)*

Therefore, although procedural approaches caused some of the care managers to experience professional 'tensions', other care managers embraced 'client-processing' and coped with any tensions this might present relatively easily.

Despite the findings of researchers like Howe, Ellis *et al* and Postle, the extent to which managerialism has either eliminated or reduced the exercise of discretion has been contested (Lewis and Glennerster, 1996; Baldwin, 2000; Evans and Harris, 2004; Harris and White, 2009). Halford and Leonard (1999) point out that the presence of a dominant managerialist discourse does not mean that individual managers' identities and workplace behaviour necessarily reflect that discourse. In any event, Baldwin (2000) found considerable evidence of care managers actively resisting managerial controls in various ways. Care managers adopted their own preferred methods of working. For example, some practice decisions were based on traditional ways of working rather than on the requirements of new procedures (p. 44). There was also evidence of care managers making unimaginative or stereotypical responses to individual need (p.166). Such practices were not necessarily the result of deliberate subversion. For example, Baldwin found care managers who clearly espoused the policy rhetoric but who actually struggled to put it into operation in the rule-constrained climates in which they worked. Therefore, following the bureaucratisation of adult social work, care managers not only found ways of using discretion, they used it in a variety of different ways and not necessarily in ways resistant to the bureaucratic controls imposed upon them.

In a Swedish study, Dunér and Nordström (2006) observed the ways in which care managers treated and responded to enquiries and applications from older people.

They identified four main discretionary techniques that care managers used in the decision-making process. These were (a) **'reject'**, which either involved diverting enquiries so that no formal application was made or giving only selected information; (b) **'execute'**, which involved using discretion in adapting vague enquires so that certain applications could be granted – but only if the care managers felt that the older person could be put into a convenient bureaucratic category; (c) **'transform needs'** which involved a greater degree of individual investigation and subsequent negotiation to ensure that applicants' wishes were granted; and (d) **'control'** where care managers exercised control by checking whether a need existed according to guidelines and ascertaining whether any assistance provided corresponded to needs. Dunér and Nordström conclude that:

Even though care managers in Swedish eldercare can be described as having relatively broad discretion, they use it only to a limited extent. Instead of using their structural power, they allow themselves to be controlled by organisational and administrative guidelines when deciding whether or not to grant assistance. They can be understood as using their intentional power when they manipulate the decision process in the direction that suits the organisation (p.441).

Dunér and Nordström found that, whilst the care managers were invested with the 'structural power' through the law to make decisions about the distribution of resources, they mainly used their 'intentional power' (*de facto* discretion) to modify the expectations of the older applicants of what services they might receive to fit in with the prevailing conditions. Therefore, the use of discretion in Dunér and Nordström's study, as with others, was not always found to be about resisting management agendas or subverting organisational guidance. Often this is done for pragmatic reasons in order to make life under pressure easier. For example, in her

study of how care managers made decisions about how to implement direct payments, Ellis (2007) found that when care managers imagined that service users were either unwilling or incompetent to use direct payments they were not offered them in the first place. This leads Ellis to conclude that:

Social workers are behaving as street-level bureaucrats, attributing people with those characteristics which make it easiest for them to routinize responses in a context of conflicting demands on their time and other resources (p.418).

In the context of the specific discussion concerning the impact of managerialism, she states that:

.....despite ten years of managerialism in the course of which professional practice has been routinized and regulated, Lipsky's work is still useful in analysing front line behaviour ... (p.405).

Many of these studies have focused almost exclusively on the use of discretion by front-line practitioners and its curtailment or otherwise by managerialist regimes. However, more recent studies such as that of Evans and Harris (2004) have raised questions of whether it is possible to understand fully how public policy is implemented in social services organisations by focusing only on front-line practitioners. As a consequence, the discretionary role played by managers in shaping policy implementation has been brought into the foreground.

Based on his research carried out into two adult social care teams in the early 2000s, Evans (2010a) claims that Lipsky's thesis contains certain 'sweeping assumptions' and that the original thesis requires some adaptation in order to take account of how discretionary power plays out in complex ways throughout the whole

organisational hierarchy and not just at the front-line. Evans also argues that the theory needs to incorporate an understanding of how ideas about professionalism and professional status interact with the role and activities of managers to variously impact on social workers' practice. As a consequence, the original simple, antagonistic model of manager-practitioner relations requires revision. This is because, as Evans explains:

Lipsky assumes that managers are a homogenous [sic] group and that they act simply as policy lieutenants - taking and applying policy as best they can. There is evidence, however, that management hierarchies in social services are fractured, with a key division between centre and periphery ..... Managers, from a professional background, tend not to define their loyalties in exclusively organisational terms ..... Furthermore, the view that policy is communicated in a pristine state is implausible. Policy has percolated through several political levels before it reaches street level... (2010b: 5).

Evans brings into sharper focus a more complex reality where policy is mediated at different levels in an organisation. From Evans' perspective, managers are as important as front-line practitioners in mediating policy. Furthermore, argues Evans (2010a, pp. 88-99), all managers are not the same.

In widening the discussion to include the role of managers, Evans draws our attention to the broader debates about the impact of managerialism on social work in the UK. Evans and Harris (2004) believe that, generally, the 'curtailment of discretion' perspective is overly deterministic and based on two flawed assumptions: the success of both managerial control and of worker compliance. The effect of both

has been overstated, which is why they refer to the death of discretion being 'exaggerated'. They argue that, in such circumstances, there is a need:

...to recognize the gradations of power that exist in the relationship between managers and professional workers within public services. Once these gradations are recognized, it becomes clear that discretion is not an 'all-or-nothing' phenomenon (2004: 881).

For Evans and Harris, what Howe refers to as 'matters of style' are not that easily left to one side. They argue that how practitioners use the discretionary space available to them to decide how procedures should be implemented remains of critical importance. According to Evans and Harris, there is a paradox: the more elaborate the rules, procedures and guidelines that are issued from on high, the more uncertainty and ambiguity are created for those whose job it is to put them into practice. Thus front-line workers are both allowed and, indeed, required to employ discretion – something with which managers tacitly collude because it obscures matters of accountability. From his study of two adult social care teams, Evans (2010b) concludes:

Lipsky's characterisation of street-level bureaucracies is... more in tune with contemporary social services than his critics acknowledge (p.4).

Ellis (2011) supports this assessment and, reflecting her long-term interest in the applicability of Lipsky to adult social care, draws on four of her own studies to construct 'a taxonomy of front-line discretion in adult social care' (p.231). From this exercise, Ellis concluded that understanding the specific discursive context in which the exercise of discretion took place was important and that rather than 'simply argue for or against the survival of street-level bureaucracy within post-managerialist

social care' (p.240), the use of discretion needs to be seen as taking distinct forms which reflect the 'micro-cultures of front-line practice' in respect of specific areas of service provision within specific organisations. Ellis finally argues that:

....to demonstrate that frontline decision making represents a dynamic interaction between the countervailing forces of top-down authority and street-level discretion, the precise characteristics of which in any given policy field can only be determined through empirical inquiry (p.241).

The recent studies of Evans (2010a) and Ellis (2011) provide a strong case for adopting Lipsky's framework of 'street-level bureaucracy' as the conceptual lens through which to study the discretionary roles played by both practitioners *and* managers in the statutory care home review system, albeit with certain important modifications. Ellis (2011) advises that the precise dynamics of discretion in any specific area of service provision can only be determined by empirical study of that service.

### **Street-level bureaucracy and service users**

Following Ellis' advice, given that a specific research objective was to observe the role played by the older person in his or her own statutory care review, not only does the exercise of discretion by the 'street-level bureaucrat' (the care manager conducting the review in this case) need to be examined, but also the ways in which the care manager facilitates (or not) the older person's involvement is also of key concern. This alerts us to the fact that Lipsky developed his ideas at a time before notions of 'user-involvement' had become entrenched in public service discourses and, as a consequence, he gave the service user's perspective relatively little

consideration. This omission has subsequently been highlighted by, for example, Manthorpe (2001), Cowan and Hitchings (2007), and Ellis (2011).

However, with some prescience, writing in 1980, Lipsky stated:

The clients of service must become a more potent force in the reference groups of street-level bureaucrats. Ways must be discovered to make visible and accessible the behaviour of lower-level workers, and clients likely to be affected by their actions must become more involved in the definition of good practice (1980: 208).

Lipsky does recognise that the 'people processing mentality' adopted by street-level bureaucrats inevitably makes a 'considerable impact on people's lives' (1980: 4) and he also recognises that, thus processed, service-users, as 'bureaucratic subjects', might 'feel obliged to temper their demands (1980: xiv). In fact, Lipsky argues that the actions of street-level bureaucrats 'hold the keys to a dimension of citizenship' (*ibid*). Nevertheless, these few observations apart, whilst recognising it as a consideration for future studies, Lipsky does not explore the role played by the users of public services to any meaningful degree. To ignore such a dimension to any study of contemporary public services in the UK would be a major omission, not least because, in recent years, considerations about how to involve 'the clients of service' have been more widely accepted both in all areas of public services (and social research).

Statutory care home reviews, therefore, take place in a discursive environment in both social care policy and practice where, since the 1980s, concepts of 'user-involvement' or 'participation' have become strongly embedded. There are two broad sets of reasons for this, both of which sought to 'empower' users of public services



(Beresford, 2010). First, 'top down' approaches were informed by the desire to introduce market consumerism to public services and constructed service users as 'consumers'. Second and at the same time, more 'bottom up' approaches were aimed at shifting political power over services towards the users of those services (Croft and Beresford, 1996; Braye, 2000; Beresford, 2010). The community care reforms of the 1990s described in Chapter Two essentially embodied a 'top-down' approach to participation, in that the model of empowerment was organised around the principle of supposed consumer choice in a care market (Beresford and Croft, 1993, Barnes and Prior, 1995; Barnes and Walker, 1996; Harris and White, 2009). The extent to which the reforms genuinely 'empowered' people in terms of a real shift of power from professional to service user is highly questionable (Jack, 1995; Clarke, 1998; Beresford, 2001).

New Labour policies of 'modernisation' and 'transformation' (Department of Health, 1998; 2005; 2006, H.M. Government, 2007) have both accelerated the privatisation and marketisation of social care and continued to promote the notion of users of social care services as autonomous and informed 'citizen-consumers' (Department of Health, 1998; Clarke *et al.*, 2000; Harris, 2003; Department of Health, 2005; Department of Health, 2006; H.M. Government, 2007; Harris and White, 2009). However, it has been argued that the reform of the social care system along quasi-market principles has not necessarily been understood by 'consumers' and that the people using the services "do not know the rules and cannot use the systems" (Baldock, 2003: 68). Despite these and other reservations about the effects of 'transformation', the Conservative led coalition has broadly adopted the same

approach to adult social care, informed by a similar ideology about active citizen-consumers (Department of Health, 2010b).

Therefore, any control or power that 'consumer choice' alone gives to care home residents is so highly circumscribed to be practically meaningless (Harris and White, 2009). They have no effective power of 'exit' from the market (Denney, 1998).

Burgner (1996), for example, found that many older people in care homes do not have a real choice.

Residents in a care setting feel and often are in a weak position as customers. They may be reluctant to complain, fearing that they will damage their relationship with the care staff or the homeowner/manager. They cannot easily leave for another home so they will naturally be cautious about appearing to cause trouble (Burgner, 1996, para. 4.12.3).

For most care home residents, the lack of any real alternative is therefore an important factor in the extent to which they can possess any power through 'exit', in the sense of having any real choice in being able to leave the care home (OFT, 2005; Help the Aged, 2007). This mechanism of consumerism is not available to them. Not only can they not perform as 'citizen-consumers', their situation effectively makes them 'incomplete consumers' (Bauman, 1998), substantially powerless to change unsatisfactory service arrangements.

Putting aside the exercise of 'choice' as a citizen-consumer, involvement can take different forms, ranging from information-giving, consultation and various degrees of participation through to full control over the service (Barnes and Walker, 1996; Carr, 2004; Warren, 2007; Means *et al.*, 2008). Whilst consultation offers only a minimal

form of empowerment, it does, in theory, provide an opportunity for 'voice' (Denney, 2008). In this approach, the service user has the 'power' to comment on or complain about the service with the expectation that their comments will be acted upon. Some writers have highlighted how consultation exercises where those consulted have no control over the consultation process itself might, paradoxically, reinforce a sense of powerlessness rather than empower (Barnes and Kendall, 2001). Yet, this is the form of user-involvement that a care home review would appear to most closely resemble and that policy consistently seems to require (Department of Health, 1991a, 1991b; Department of Health, 2002b, Department of Health, 2002c; H.M. Government, 2007). Essentially, it is an opportunity for the service to be monitored and evaluated with some input from the service user. However, making this activity work effectively is problematic, because, apart from the difficulties highlighted by Burgner, another difficulty in using either 'choice' or 'voice' approaches with care home residents lies in the fact that many have significant mental impairments and cannot necessarily represent their own interests effectively (Bowman *et al.*, 2004; Help the Aged, 2007). Despite this reality, policy directed at care homes implies that ways of working need to be found that enables residents to play a 'full part' in how their placement is reviewed (Department of Health, 1998).

The challenges that reviewers face in trying to involve and promote the best interests of older people in care homes are, therefore, potentially complex. The ways that care managers can influence the extent to which older people are meaningfully involved in their own reviews are discussed later in Chapter Seven. However, as discussed in Chapter Two, whether the introduction of care management as a consequence of the community care reforms, has equipped practitioners with the necessary knowledge,

skills, values and resources required to meet these challenges is a matter of some debate.

## **Conclusion**

For the reasons outlined above, the concept of street-level bureaucracy retains a significant degree of analytical power and usefulness as a conceptual framework for examining how the system of statutory care home reviews is implemented in a challenging context of ambiguous agendas and scarce resources. For example, Lipsky provides valuable insights into how and why street-level bureaucrats develop a 'client-processing mentality' in such circumstances and what this means in terms of practice. However, the central reason for using Lipsky as a conceptual lens is the primacy given to the idea that practitioners exercise discretion in how they implement policy. Critiques of Lipsky based on studies mainly carried out in the context of social work in the UK (notably Evans, 2010a) suggest that he was overly focused on the exercise of discretion by front-line practitioners and that he has given too little attention to other key players in the process including managers and service-users. In Chapter Two I highlighted that in today's marketised, modernised and substantially privatised adult social care system, the 'public' service of care home provision has become more fragmented with a multiplication of actors involved in its operation. I argued that, as a consequence, discretion was more widely dispersed. Consequently, a more holistic approach to understanding the statutory care home review system and one that fully acknowledges its complexity needs to look beyond the 'street-level bureaucrat' as originally formulated by Lipsky and include the perspectives of all those whose decisions variously impact on shaping the system. These perspectives derive from not only front-line practitioners, different

tiers of manager and service providers but also those who stand to be affected by the way the system operates – not just the service user, but their relatives and those who provide their care. It is with these considerations in mind that, ultimately, a case study approach was adopted in order to examine how the system operated in one local authority. Discussion of the methodology follows in the next chapter in which I explain the specific aim and objectives of the case study, the choice of methods used and both the ontological and epistemological positions underpinning the study.

## **Chapter Four: Methodology**

### **Introduction**

This chapter begins by restating the aim and objectives of the research followed by an explanation of how the methodological decision-making in relation to this study developed. I explain how a pilot study was conducted in order to assist with the theoretical and practical decisions concerning the research design as well as with the goal of developing a better understanding of ethical considerations relating to the study. In discussing the pilot study in more detail, I describe how, whilst the pilot was successful in many respects, subsequent difficulties in accessing the field required the research to be redesigned as a case study with a slightly revised focus from that originally proposed. The chapter then discusses critically the choice of case study design; the methods of data collection adopted, together with justification of the method of data analysis. Thereafter, attention is given to the ontological and epistemological assumptions underpinning the study. The chapter ends with a discussion of my relationship to the field as a researcher.

### **Aim and objectives**

As stated in Chapter One the overall aim of the project was to obtain an understanding of how the system of statutory care home reviews operated and was experienced by those involved in it. Specific objectives were:

- To explore and explain the various purposes that statutory care home reviews serve in terms of both policy and practice.

- To examine and compare different stakeholder perspectives on the review process; including managerial, practitioner; service-user, relatives and care home staff.
- To observe, in particular, the roles of the reviewer and the older person in the review process.
- To assess the relevance of 'street-level bureaucracy' (Lipsky, 1980) as a conceptual lens with which to analyse and explain the practice of statutory care home reviews, particularly in respect of the use of discretion.

The PhD started in October 2006 and a full chronology of the data collection process, together with an anonymised key to who was involved can be found in Appendix 3. The following section discusses the key decisions taken in order to help with designing a study that would achieve the research aims and objectives, starting with the decision, in February 2007, to set up a pilot study in order to assess what was 'do-able'.

## **Pilot Study**

Pilot studies perform a wide range of useful functions in social research and are considered to be an important stage early in the research process (Sarantakos, 2005). As Van Teijlingen and Hundley (2001) highlight:

Pilot studies are a crucial element of a good study design. Conducting a pilot study does not guarantee success in the main study, but it does increase the likelihood (Van Teijlingen and Hundley, 2001:1).

In this case the purposes of the pilot study included helping to focus the research questions, assessing feasibility and also gaining a better understanding of any ethical issues connected with entering the field, observing statutory care home reviews and interviewing review participants. The pilot was also undertaken on the understanding that any data collected at that stage could contribute towards the final study (Arthur and Nazroo, 2003).

### **Ethical considerations**

Formal ethical approval was required in order to undertake the pilot study. This process necessarily required thinking through all the potential ethical concerns.

According to Denzin and Lincoln (2002):

Traditionally, ethical concerns have revolved around the topics of informed consent (receiving consent by the subject after having carefully and truthfully informed him or her about the research), right to privacy (protecting the identity of the subject), and protection from harm (physical, emotional, or any other kind) (Denzin and Lincoln, 2000: 622).

Formally satisfying these concerns required gaining approval from two bodies. In line with The Open University research governance requirements, ethical approval to undertake this project was sought and granted by The Open University Human Participants and Materials Ethics Committee<sup>7</sup> (OU HPMEC) prior to field work commencing. The fact that some of the research subjects, because of their physical and mental impairments, might be more at risk was addressed in the approval

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<sup>7</sup> The HMPEC was renamed the Human Research Ethics Committee (HREC) in January 2011.



process. This required including copies of appropriately worded participant information sheets and consent forms which could be read to people if necessary (see Appendix 1). Approval was granted in May 2007.

In addition to the University requirements, the local authority where the research took place (the County) operated its own 'Research Governance Framework' which, regardless of any prior ethical approval process, required anyone doing research in social care for adults to submit a proposal for approval. This needed to cover, amongst other considerations, the reason for the research, the methodology, ethical issues (particularly concerning the treatment of 'vulnerable' adults) and proposed dissemination strategies. Approval was granted in July 2007. The research was therefore undertaken with the full knowledge and approval of the County.

When formal approval was gained, the process of informed consent was considered and, as many writers have stressed (for example, Denzin and Lincoln, 2000; Lewis, 2003; Silverman, 2005), this needed to be *ongoing* consent. Therefore, checking that all the potential participants had clear information and that they were voluntarily giving their consent to participate was an ongoing task. It was made clear to participants throughout all stages of the process that they could withdraw at any time.

One of the main ethical considerations was ensuring that the older person involved was fully aware of what the research was about *and* of their right either not to participate or to withdraw at any stage. Because access to the older person was always via an intermediary – for example, a family relative, social worker or member

of the care staff in the home, such a recruitment strategy could actually make it harder for the older person to decline to participate with a 'powerful alliance' ranged against them. Therefore, this needed to be handled sensitively. If it looked as if they were agreeing to please the intermediary and that they would rather not participate, then this indicated a subtle abuse of power and needed to be rethought.

Even once genuinely informed consent was given at the pilot stage, the need for ethical research practices was ongoing. In fact, gaining ethical approval from the OU HPMEC was not a one-off event, it was an on-going process. For example, the decision to revise the research design, after the pilot stage, to include interviewing additional older care home residents other than those involved in the reviews I had observed, involved seeking further ethical approval.

It was important to consider the ethical dimensions to the different data collection methods chosen. For example, interviews were going to be used and with this method, as Lewis (2003) states:

It is important to be alert to signs of discomfort, and if these are given to check the participant's willingness to continue or to offer to stop the interview. It will sometimes be necessary to stay after the interview has concluded, to respond to any anxieties about confidentiality and to give the participant an opportunity to return to some of the issues discussed, or to turn to more everyday subjects, outside the context of the interview (p.69).

This advice was particularly applicable to the interviews with the older people. This was because although, care home residents are not a homogeneous group, as indicated in Chapter Two, the incidence of sensory and cognitive impairment is higher than that in the general population. This suggested that extra attention needed to be paid in avoiding any possible misunderstanding or confusion which may be a consequence of such impairments. Establishing a good rapport and gaining trust is vital and, here, both sensitivity to the needs of the interviewee and researcher reflexivity are key (Clarke, 2006).

As noted above, submissions for ethical approval from both the OU HPMEC and the County's approval panel were granted and the data collection stage of the pilot study commenced in autumn 2007.

### **Outline of the Pilot Study**

A fuller, more critical, discussion of all the research methods adopted follows later in the chapter. However, to summarise, the pilot study consisted of the observation of two statutory care home reviews followed, where it was possible, by semi-structured interviews with key review participants, i.e. the older person, their carer (if in attendance) and the reviewer, plus subsequent analysis of the completed review records. At the pilot stage, the main focus was on the perspectives of two main 'central actors': the care manager (the reviewer) and the older person. The main objective of observing was to find out what reviews actually consisted of in terms of how they were organised and carried out and how the reviewer involved the older person in the process. From the interviews, the objectives included gaining a sense

from each of the central actors of how they thought the review had gone; what its purpose was; what it had achieved and whether the older person had felt involved in the process.

The first observation took place at The Oaks <sup>8</sup>(a care home run by a local housing association) of a care manager in the 'North City' locality team (CM1) reviewing the placement of a female resident (OP1). OP1 had mental capacity and there was no one else present. The second observation took place at The Cherry Trees (a privately run care home with nursing) of a care manager (CM 2) from the same team reviewing the placement of a male resident with dementia (OP 2) who lacked mental capacity. On this occasion the review also included the resident's wife (Mrs OP 2). On both occasions, as well as interviewing the care managers involved, it was possible to obtain the paperwork for the completed review for analysis.

The full findings from the pilot are incorporated into later chapters. However, in terms of both the feasibility and suitability of methods, the pilot study showed that it was ethically and practically possible to organise and carry out observations of two different care home reviews involving different care managers and older people. Early analysis of the findings from the observational, interview and documentary data revealed that, despite the standardised format adopted by the local authority, the care managers interpreted the process differently in each case. This suggested that approaching the research through the lens of 'street-level bureaucracy' (Lipsky,

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<sup>8</sup> More information about the care homes in which data collection took place is provided in Appendix 4

<sup>10</sup> This was delivered by Liz Spencer at a workshop run by the Social Research Association in February 2009)

1980) with its central concept of the use of practitioner discretion, was a useful conceptual framework through which to examine practices.

The pilot study created the opportunity to test the methods and to give more consideration to the procedures that would be adopted for data management and analysis. Both the observations and interviews were (audio) digitally recorded, transcribed and then transferred to NVivo 7 (later NVivo 8) primarily as a data management tool, but also to assist the processes of indexing, coding and analysis. This was supplemented with field notes either made contemporaneously or following a period of reflection.

### **Method of analysis**

Notwithstanding the stated aim of assessing the value of using the concept of 'street-level bureaucrat' as a lens through which to examine the data, the pilot study also provided an opportunity to examine an approach toward data analysis informed by grounded theory (Glaser and Strauss, 1968). I recognise that, not only are there multiple interpretations of grounded theory (Bryman, 2004; Hammersley, 2005), but that the label 'grounded theory' is often used as 'an approving bumper sticker' of academic respectability in qualitative research (Bryman and Burgess, 1994: 6).

Bryman (2004) has commented that:

Some writers have suggested that grounded theory is honoured more in the breach than in the observance, implying that claims are often made that grounded theory has been used but that evidence of this being the case is at best uncertain (p.401).

However, the decision to try out a grounded theory approach to analysis in the pilot study was taken not only because of its widespread popularity and application in qualitative research (Bryman, 2004), but also because of the arguments made on its behalf in terms of ensuring rigour through iteration (Glaser and Strauss, 1968; Ryan and Bernard, 2003). As Ryan and Bernard (2003) explain:

Grounded theory is an iterative process by which the analyst becomes more and more "grounded" in the data and develops increasingly richer concepts and models of how the phenomenon being studied really works (p.279).

Although aware that the approach has its critics for various reasons (see for example, Thomas and James, 2006), it seemed appropriate, at least at the pilot stage, to give careful consideration to its potential usefulness. The 'constructivist' approach to grounded theory expounded by Charmaz (2000), where the researcher has more interpretative licence, offered a possible way forward.

Nevertheless, as the pilot study progressed, it was important to clarify an analytical method that was clear and coherent, fit for purpose and that could be confidently used through to the completion of the project. On one hand, grounded theory provided an approach that promised a degree of rigour which would assist with generalisation and theory building (Payne and Williams, 2005). On the other hand, it required a completely open mind towards interpretation (Thomas and James, 2006) which was both unrealistic and difficult to reconcile with the decision to apply *a priori* concepts and look for certain themes. In addition, the danger of fragmenting or atomising the data and therefore losing, as Bryman points out, 'a sense of context and narrative flow' (2004:407) was recognised. After further deliberation, a

'Framework' approach to analysis was adopted (Ritchie and Spencer, 1994).

According to Ritchie *et al.* (2003):

The name 'Framework' comes from the 'thematic framework' which is the central component of the method. The thematic framework is used to classify and organise data according to key themes, concepts and emergent categories. As such, each study has a distinct thematic framework comprising a series of main themes, subdivided by a succession of related subtopics (p.220).

Framework analysis rather than, say, a grounded theory approach was more suitable for this research, not only because the study started with wanting to know the answers to specific questions but also because there were *a priori* issues to be examined such as the those suggested by Lipsky (Srivastava and Thomson, 2009). In order to acquire the necessary skills I attended Framework training<sup>10</sup>. The analytical approach taken therefore involved a process beginning with labelling, sorting and comparing the data - 'familiarisation' - (Ritchie *et al.*, 2003: 21) and progressing to noting recurring themes and devising a conceptual framework. At points throughout the process I wrote summaries in order to assist with the process of synthesising and interpreting what was being found. The whole process was iterative and began at the point of first collecting data and continued into the writing up stage. However, the process was valuable because, as Ritchie *et al.* (2003) state:

....the process of actually writing a summarised or synthesised account begins to trigger the vital insights into, or questions about, the data that will lead to the later interpretative stages of analysis (p.237).

'Framework' allowed the process of analysis to be systematic and transparent without being overly mechanistic or doctrinaire and as Braun and Clarke (2006) argue, thematic analysis is a valid qualitative method in its own right and need not be linked to grounded theory or any other of the major analytic traditions.

Overall, the pilot study confirmed that the research procedures and methods used were ethical, fit for purpose and could generate data about which, with further analysis, one could be reasonably confident about the findings. The success of the pilot confirmed the decision to organise a further six to eight review observations based on reviews that would naturally occur and which, for comparative purposes, were to involve different care managers from different teams across the County. Including the reviews observed in the pilot, this would have meant a sample of eight to ten review observations altogether. This size of sample would have enabled a degree of diversity in terms of the care home, resident and locality team that could be studied. However, it soon became apparent that the pilot had created a misleading picture of how easy it would be to gain further access to the field.

## **Post-pilot: negotiating further access and refining the methodology**

### **Access**

Recruiting further local authority care managers who were willing to be observed conducting a review proved much more difficult than was anticipated and the twelve month period from September 2008 to September 2009 yielded only one more review observation. There were, therefore, three reviews observed altogether – well



short of the eight to ten originally hoped for. In the event, the protracted process of, largely unsuccessful, field negotiations with various gatekeepers actually provided, on reflection, many important insights into the specific field under study. In fact, it highlighted that difficulties in gaining field access are often under-reported in research accounts and that valuable lessons can go unlearned as a consequence (Wolff, 2004). Because of this I describe this process in more detail in Chapter Nine where I provide more critical reflections on the reasons behind care managers' reluctance to participate in the study and the various strategies employed to resist involvement. However, at the time, the effect of being faced with a significantly smaller sample of observations than was originally planned, required the research to be redesigned to take this into account.

Building on the data already collected and using the experience of field access negotiations as data in its own right, I decided to broaden the focus of the project. Whereas the original aim was to focus on the experiences of the key participants (reviewer and older person) in a selected number of reviews and investigate and compare the different meanings each participant attached to the experience, the problems with obtaining observational data led me to decide to redesign the research broadening its focus into a case study of how the statutory care home review *system* operated in that particular local authority. I decided to develop an in-depth case study building on the three observed events. This required expanding my data sources. This would involve collecting additional interview data from other stakeholders who had some form of involvement in the care home review system. These stakeholders included senior managers within the local authority, locality team managers, a Care Quality Commission (CQC) care home inspector, care home

managers, relatives and residents. Thus, it became possible to gather multiple perspectives both on what the purpose of reviews was and also on how the review system was operating. Using a multi-method approach which included collecting relevant documentary data, such as review forms, checklists and completed reports enabled a comparison of practitioner's accounts of their practice with their actual practice, particularly in respect of how they facilitated the older people's involvement in the review process.

### **Choice of case study design**

Tight (2009) argues that the description 'case study' is overused in qualitative research and has become too vague a term to be meaningful. He proposes that, in the cause of clarity, researchers should avoid the temptation to 'conveniently label' as a case study, what are often, essentially, 'small scale' studies. However, against this view, there is a significant body of opinion that would actually justify the selection of a case study for this research. Lewis (2003), for example, explains that the qualitative case study's defining characteristics are:

..... that it draws in multiple perspectives (whether through single or multiple data collection methods) and is rooted in a specific context which is seen as critical to understanding the researched phenomena. The study may involve a single case but more commonly in applied research involves multiple cases, selected carefully to enable comparison (p.76).

More specifically relevant to this case, Hartley (2004) emphasises the need to understand the impact of, for example, the organisational context in such research, asserting that:

Case studies are useful where it is important to understand how the organizational and environmental context is having an impact on or influencing social processes. Case studies can be useful in illuminating behaviour which may only be fully understandable in the context of the wider forces operating within or on the organization, whether these are contemporary or historical..... (p.325).

In a similar vein, Swanborn (2010) proposed that:

A case study refers to the study of a social phenomenon....in which the researcher focuses on process-tracing: the description and explanation of social processes that unfold between persons participating in the process, people with their values, expectations, opinions, perceptions, resources, controversies, decisions, mutual relations and behaviour, or the description and explanation of processes within and between social institutions.... (p.13).

Notwithstanding Tight's objections, there is a clearly discernible consensus about what a case study approach comprises, what role it can play and what reasons there might be for adopting one. Key features of a case study approach that made it attractive to fit the purposes of this project were that it implies an in-depth, empirical examination of a particular phenomenon, often using mixed methods of data collection and investigated *in its real life context*.

I therefore decided to make the statutory care home review *system* in the County the focus of the case study because understanding the practices around individual care home reviews could not really be fully understood without putting them in the wider policy and organisational contexts in which they took place and, at the same time, trying to understand the 'social processes' that unfolded between those participating in the process.

The decision to adopt a qualitative case study approach would be further justified by the fact that this research design has been of demonstrable use in areas of public service such as education, nursing and social work for many years (Shaw and Gould, 2001; Simons, 2010). More specifically, it has a growing track record in the world of adult social care (Ellis *et al.* 1999; Evans and Harris, 2004; Evans, 2007). Empirically, the pilot study was able to provide confirmation that such an approach was likely to be as helpful in answering research questions in another particular area of social care. In fact, it is intended that both the value and validity of this study will lie in being able to engage with and contribute to a dialogue with this strand of academic discourse (Flyvbjerg, 2004). Chapter Eight, for example, draws upon the empirical findings to inform the debate, highlighted in Chapter Three, about whether and how discretion is exercised in the adult social care system.

In terms of identifying which 'type' of case this is, Yin (2004) provides three broad categories of case study - exploratory, descriptive and explanatory. As far as this case study is concerned, there are elements of each of these but with more emphasis on the 'explanatory'. However, the way it has been conceived, this study

could most appropriately be defined as 'an exemplifying case' (Bryman, 2004: 51), in that it is reasonable to assume that the County shares many characteristics with other local authorities in England in the way its statutory review system operates and that findings might exemplify characteristics of other local authorities. This raises questions about generalisation.

## **Ensuring rigour**

The conventional wisdom about case study research is that it is subjective, lacks validity and, whilst possibly useful in pilot studies, 'cannot provide reliable information about the broader class' (Flyvbjerg, 2004: 360). However, it is claimed, increasingly, that case study findings can be treated with as much confidence as those from other qualitative designs - as long as sufficiently robust and transparent processes are followed (Stake, 2000; Robson, 2002; Bryman, 2004; Flyvbjerg, 2004; Yin, 2004; Simons, 2010). This raises the question of what would constitute a sufficiently robust process in this instance and suggested that it was necessary to think about whether triangulation was possible and in what way.

According to Ritchie (2003: 43):

Triangulation involves the use of different methods and sources to check the integrity of, or extend, inferences from the data. It has been widely adopted and developed as a concept by qualitative researchers as a means of investigating the 'convergence' of both the data and the conclusions derived from them.

This study used mixed methods suggesting that it could be triangulated using multiple sources of data (Bryman, 2004; Denzin, 1984; Yin, 2004). At least three of what Yin identified as primary sources of case study evidence are used in this study: observation data, interview data and documentation, each derived from a different research method. However, as I explain more fully later in this chapter, whilst I was interested in what went on from my perspective of observer, I was equally interested in exploring different stakeholders' perspectives on the review process. This was based (as explained later in this chapter) on a social constructionist ontology and I did not necessarily expect either convergence of opinion or the emergence of an incontestable, single reality. Gomm (2009) argues that from this point of view:

...triangulation makes no sense, since each version will be regarded as the outcome of the way it was produced, and there is no particular expectation that any two versions will agree (p.367).

However, the fact that the data from different sources or from different methods might not necessarily 'agree' need not eliminate the value of cross checking data from different research methods. In fact, as much might be learned from 'divergence' as from 'convergence'. For example, the researcher would be interested in discrepancies that might be found comparing data from observing practices and data gathered from verbal and written accounts of those practices. Similarly, comparing different versions from different participants would help the researcher learn more about the 'multiple realities' that might exist for the different actors involved in the case.

Citing Hammersley (1992), Lewis and Ritchie (2003:276) explain how, in qualitative research, we can never know with certainty that an account is 'true'. They say that therefore:

We must judge validity on the basis of the adequacy of the evidence offered in support of the phenomena being described (p.276).

One method I explored was the use of participant validation in order to establish 'the adequacy of the evidence'. Silverman (2010) considers this a 'flawed' method (p.278) and urges caution, citing Fielding and Fielding (1986) who argue:

...there is no reason to assume that members have privileged status as commentators on their actions ... such feedback cannot be taken as direct validation or refutation of the observer's inferences. Rather such processes of so-called 'validation' should be treated as yet another source of data and insight (1986: 43; cited in Silverman, 2010: 278).

Therefore, I remained cautious about attributing a privileged status to participants' accounts but, nevertheless took the view that some feedback from participants would be useful in testing, confirming and refining ideas and themes derived from analysis. To begin with, all transcripts were offered to any interviewee to check for accuracy within reasonable timescale, although no one took up this offer. This did not always take place because by the time I was in a position to share interpretations, some managers and workers had changed job and one of the older participants had died. In the case of relatives, they appeared happy just to provide their account. However, whilst in the field, I took the opportunity to discuss emerging

themes with as many participants as possible. This proved to be a useful exercise which, in some ways, helped to enrich interpretation. It also served to confirm certain themes that will be discussed more fully in subsequent Chapters.

## **Generalisation**

Questions can always be raised about the feasibility of generalisability in most, if not all, research (Lincoln and Guba, 2000). The small sample size of most case studies means that, apart from rigour, a perceived lack of generalisability is considered a particular weakness. However, case study research is not based on statistical sampling and there should be no attempt to generalise on the basis of numerical representativeness. Most qualitative case studies, including this one, are therefore based on 'purposive' sampling. In such studies, Yin (2004) stresses the distinction between statistical generalisation and analytical generalisation. Analytic<sup>11</sup> generalisation involves using the empirical results from the case study to compare with the theoretical propositions developed from previously researched studies. The outcome can be a confirmation or refinement on the basis of the particular findings of the new study. Therefore, as explained earlier, in this study it was intended to engage with a critical dialogue with previous studies of adult social care that have also adopted the conceptual lens of 'street-level bureaucracy' (Lipsky, 1980), with a view to either confirming or refining the explanatory relevance of the concept.

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<sup>11</sup> Yin uses the terms 'analytic' and 'analytical' interchangeably.



Swanborn (2010) argues that what Yin called 'analytic generalisation' should be more appropriately thought of as 'domain generalisation' and, sounding a cautionary note, states that:

...the validity of our conclusions with respect to non-researched cases is a matter of more or less plausible arguments. In follow up research our extrapolations may well be refuted (p.70).

As a case study researcher I recognise this and, therefore, take a cautious approach to how far any results or conclusions can be generalised. Here the concept of 'moderatum generalisation' developed by Payne and Williams (2005) provided a way forward and offered theoretical coherence.

### ***Moderatum generalisation***

Through the concept of 'moderatum generalisation', Payne and Williams (2005) offer a pragmatic, and 'moderate' solution to the challenge of making meaningful generalisations from case studies. Arguing that any such generalisations should be both tentative and provisional, Payne and Williams, argue that the skill lies in how claims are formulated. As they explain:

[moderatum generalisations] are moderate in two senses. First, the scope of what is claimed is moderate. .... Second, they are moderately held, in the sense of a political or aesthetic view that is open to change.....Although moderatum generalization [sic] is inherently modest, it cannot be taken to occur naturally and automatically in the process of doing research, or be left to the readers' discretion, or indeed, to the kinds of generalization that current qualitative researchers often seem to produce unconsciously (p.297).

....generalizations are more credible if the exposition connects the generalization to the specifics of data that provide its foundation.....Similarly, researchers should indicate their own assumptions about similarities and differences between the research site and the other ('receiving') sites, and between the research's informants and other actors. This process would not only assist the reader, but clarify in the researchers' own minds what it is that they are claiming (p.305)

As a consequence, Payne and Williams stress that, apart from "to academia", researchers need to make explicit which audience(s) they are addressing when disseminating their findings. The researcher needs to formulate conclusions from the data evidenced by sufficient description and context that the target audience would accept as valid. They also stipulate that the researcher exposes their interpretative processes and the assumptions that underpin any conclusions reached.

Therefore, to summarise, having adjusted the research aim and objectives to encompass how the statutory care home review system operated as a whole within one local authority rather than focusing more narrowly on the meanings given to the process by the older person and the reviewer, I adopted a case study design. Data would be analysed and themes identified using a Framework approach. In order to ensure that knowledge claims could be treated with confidence and taken as both plausible and credible in respect of the world it was describing (Hammersley, 1992), it was necessary to triangulate using different data sources and a mix of methods. In so doing, this would produce a richer and deeper understanding of how the review

system operated (Ritchie and Lewis, 2003), whilst acknowledging that generalisation from the study could only be moderate and open to future repudiation.

### **Mixed Method approach**

The project employed three distinct methods of inquiry: observation, in depth interviews and documentary analysis. Using different methods in qualitative research can create the potential for entanglement in paradigm confusion (Guba and Lincoln, 1994). For example, Silverman (2005: 10) cautions that the use of different methods can create potential conceptual confusion because observation belongs to a constructionist model - which prioritises interaction over meaning- while interviews belong to an emotionalist model (after Gubrium and Holstein, 1997) - which prioritises the study of meanings and perceptions. However, Silverman regards this as more a source of possible complication to be acknowledged rather than complete incompatibility. However, combining methods is positively encouraged by many writers. For example, Ritchie (2003) believes that:

...interviews are often used in combination with observation methods so that there can be understanding of how events or behaviours naturally arise as well as reconstructed perspectives on their occurrence (p.38).

Whilst observation would enable me, for example, to compare different review practices, interviewing would enable me to gather differing stakeholder perspectives on, for example, what purpose the review served and what meaning they placed on the experience. Therefore, combining methods and the 'triangulation' of observation with other sources of data increased the 'expressiveness' of the data gathered

(Flick, 2006: 218). As the aim was to produce a case study that was fine grained and holistic, this was obviously beneficial.

## **Observation**

Denzin and Lincoln (2000) talk about observation as the 'fundamental base of all research methods' (p.673) and Silverman (2005) argues that observation is of particular importance in qualitative research because it is about finding out what people actually *do* rather than hearing an account of what they do. Interviews necessarily reconstruct past events through the eyes of the interviewee. However, as Ritchie (2003) points out:

Observation offers the opportunity to record and analyse behaviour and interactions as they occur, although not as a member of the study population. This allows events, actions and experiences and so on, to be 'seen' through the eyes of the researcher, often without any construction on the part of those involved (p. 35).

Observation also allowed me to concentrate on depth rather than breadth. As explained earlier, it was originally intended that a maximum of ten 'naturally occurring' care home reviews would be observed. Here 'naturally occurring' means that the reviews were scheduled to take place anyway. However, it is acknowledged that the presence of a non-participant observer has an impact on how 'natural' the participants behave in such circumstances.

In relation to the research aim and objectives, the purpose of observation was to gain a better understanding of the review process in general, but more specifically,

to see how a particular reviewer organised a review, what processes were followed, and to observe interactions between participants with a focus on how the older person, as the subject, was involved. In this respect the observation of aspects of verbal and non-verbal communication would be important.

### ***The observer role***

There are various ways of conducting observations in social research (Hammersley and Atkinson, 1989). In this study I adopted the 'total researcher' role (Gans (1982) cited in Grbich, 1999). By this I mean that the observation was the sole purpose of the visit to the care home. Whilst I did not position myself behind a two-way mirror or remain out of view of the review participants, I was not taking on any other participant role such as social worker or care assistant in the care home. I was, as far as I could be, emotionally if not physically detached from events. However, I acknowledge that by sitting with the others in the review, I was, to some extent, participating. They were obviously aware of my presence and this would almost certainly have some, albeit unknowable, effect on events.

Rossmann and Rallis (1998) discuss how, although we all observe the world all the time, as an enquiry technique, observation is differentiated by being more systematic, diligently undertaken, purposeful and disciplined. They argue that a basic choice the researcher must make is deciding how 'prefigured' or 'open-ended' the observation will be (p.119). Therefore, the observer can tightly structure the observation with checklists and pre-decided categories in timed observations or take a more 'open-ended' approach allowing categories to emerge as the project unfolds.

Rossman and Rallis (1998) argue that an open-ended technique is more consistent with a phenomenological approach as the observations will be more 'holistic' and 'exploratory'. In this case, the research questions required certain aspects of behaviour to be looked for and recorded – for example, the degree of involvement of the older person. The goals of the research were both to understand and explore the review system. I had no firm ideas in advance of how long reviews took and what order they were carried out. Therefore, to adhere to a rigid observation schedule and/or to pre-code might have excluded data that had potentially significant relevance and interest, which would have defeated the point of the observation.

There are other aspects to observation other than watching people's behaviour. Fox (1998) talks about '*post-hoc* reflections', explaining that:

...sometimes it is only when we have had some time to reflect on an observation session that we gain some insight, often when we are re-reading the notes or perhaps even in the middle of the night! Add these insights to the notes: they form a part of the continuing 'log' of your fieldwork (p.13).

In this respect, the observations were undertaken with a reasonably open agenda but with a particular focus on a) how the care manager interpreted the format and b) how the older person was involved. Any other relevant aspects of the process not directly observed, for example, documentation, were to be noted and requested wherever possible. The observation would also recognise the usefulness of and include '*post-hoc*' reflections where appropriate.

## ***Impact of the Observer***

It is important for any social research to consider the impact of the observer on the observed and Robson (2002) cautions:

How do we know what the behaviour would have been like if it hadn't been observed?

And, moreover, whether one takes on a very detached or very involved role as an observer, or something in between, there are related methodological and ethical problems. Virtually total detachment can come across as anti-social and itself cause reactions from those observed. To be highly involved risks compromising your researcher role (Robson p.311)

It is obvious, for the reasons that Robson and others outline, that reactive behaviour to observation cannot be eliminated altogether (see, for example, Grbich, 1999:20, for a discussion of the 'Hawthorne effect' where the act of observing itself had a significant effect on the behaviour of those observed). For example, it is quite likely to surmise that, in the presence of an observer, the reviewer would be ostensibly more thorough than they would otherwise be. Therefore, I had to think about how to observe in a way that minimised any distortion of participants' behaviour. The participants had already been informed of the project and of my role and had given their formal consent to my being present. On the day of the review, I briefly introduced myself at the start and then let the care manager take charge of the review as they would normally. I decided that, for each review, within the constraints of the location (usually a bedroom), to negotiate a relatively unobtrusive position on the edge of the meeting from which to observe and take notes. Whilst I was not concealed, for most of the time I was mainly out of vision of the participants.

By their nature, observations do not always lend themselves to audio recording. However, care reviews do. I therefore decided that, having gained the consent of the participants, the reviews should be audio recorded digitally where possible. This would not only minimise the need for continuous note-taking, but also aid *post-hoc* reflection, especially during the transcription and coding stages, when reflective memos would be written and form part of the research log for later analysis. In reality, given that the observations were taking place in quite restricted spaces, contemporaneous note-taking needed to be kept to the minimum because it would have been very conspicuous and distracting from the review process.

Because each review was individual there was no set procedure of how they ended. However, generally, after each review was concluded I noted the participants' reactions, enquired what they were going to do next, thanked them and left. I considered the direct observation stage to be over once I had left the care home. Later, I requested copies of the completed review forms for examination, and these were provided.

## **Interviewing**

There are distinct advantages in combining participant observation with interviews; in particular, the data from each can be used to illuminate the other (Hammersley and Atkinson, 1995: 131).

The data collected from qualitative interviewing is potentially 'illuminating' but, at the same time, problematic. Earlier, it was noted that semi-structured and unstructured interviews belong to an 'emotionalist' model of enquiry – which is concerned with



discovering a person's inner thoughts and feelings, where observation focuses on people's actual behaviour. As Gubrium and Holstein (1997) state:

The aim is to really get "inside" to the hidden "wellsprings" of the natural, a field of experience that ethnomethodologists and others exclusively concerned with the *hows* of social life tend to neglect (p. 59). [original italics]

However, Atkinson and Silverman (1997) argue that we now live in an 'Interview Society' and call into question how far the interviewer, can authentically get inside the inner world of the interviewee. Atkinson and Silverman believe that interview responses represent versions of the 'rehearsed' self. Therefore, such personal narratives are, as they say, both 'artful' and 'constructed' (p.312). To acknowledge this point is not necessarily to dismiss the important contribution that interviews can play, nor to imply that people's experiences are fictions. However, it is to admit, as Atkinson and Silverman say, that:

The storied self of the interview is shaped by the possibility – even when not by the actuality – *of multiple tellings* (1997: 314) [original italics].

I accept the point made by Atkinson and Silverman and propose, in respect of this research, that it is reconcilable with the relativist ontological perspective which underpins this research and is discussed in more detail later in the chapter. As Silverman (2005: 45) asks about interviews 'How far is it appropriate to think that people attach a single meaning to their experiences? Equally pertinent, one might add that it also problematises the idea that a care review can capture the 'authentic' voice of the older person or any other participant. If Atkinson and Silverman's

premise is accepted, what emerges from the interview becomes an actively constructed narrative rather than a 'true' picture of reality. However, it should be reiterated that this caveat is equally as applicable to the review process itself.

How the interview was structured therefore was an important consideration. The research objectives meant that, inevitably, there was an agenda. For example, I wanted to know what meaning(s) the people involved in it attached to the review system and what they thought its purpose and uses were. These questions suggest a degree of necessary structure. However, because of the exploratory nature of the research, in addition to interviewer-led questions, I felt it was important to give the interviewee space to express any thoughts or feelings they might have, whether they related explicitly to my agenda or not. Therefore, I felt a semi-structured approach was most appropriate (Kvale, 1996; Lewis, 2003), using a thematic 'topic guide' (see Appendix 2) rather than a list of standardised questions (Arthur and Nazroo (2003). Whilst providing some structure it also allowed the interviewee to introduce his or her own themes.

Arguably, as the degree of standardisation diminishes, the skills required of the interviewer need to increase. Echoing many other writers, Becker and Bryman (2004) say that:

Effective interviewing is characterised by the extent to which the researcher can: establish rapport; ask questions and/or elicit information; listen; and record the data accurately (p.272).

To pick up on Becker and Bryman's final point first, technically recording the data accurately was not that difficult. The main recording method - a digital recorder - enabled me to produce accurate transcripts of what was said. However, I anticipated that establishing 'rapport' would prove more challenging. For example, I anticipated that, despite participant information being provided, the older person might experience some potential confusion over my role as a researcher additional to the review process. This raised ethical issues and would need to be dealt with sensitively. Also, establishing rapport with the reviewer might be made difficult if they thought their performance or professional competence was under scrutiny and became defensive. Relevantly, Legard *et al.* (2003) also say that it is important not to step outside the role of researcher, for example, to be a counsellor or advocate. Therefore, the process of establishing rapport needed to be included as part of a broader concern with the effective management of field relations generally, including impression management (Goffman, 1959), achieving appropriate social distance, role clarification and maintaining ethical standards, of which role clarification was probably the key.

There were some other potential methodological pitfalls. For example, as discussed earlier there was value in observing the review first and then interviewing participants afterwards because points observed during the review could be used to prompt the interviewee. However, this also raised the possibility of sliding into leading questions, for example, 'You looked quite confused at the beginning?' I therefore needed to avoid my own interpretations from observing colouring the language used in interviews in this way.

Given the characteristics of older people in care homes I was concerned about how to interview older people who might have communication difficulties for various reasons. However, some caution needed to be exercised in thinking around this area, because, as Low (2006) points out:

... A focus on the linguistic inability of informants, however unwitting, constructs the person who experiences difficulty speaking as problematic and the researcher as the "expert" who solves the communication problem the informant presents (p.153).

In the event, on the advice of professionals who knew the older person and relatives where present, I did not interview the older people who had dementia whose reviews I observed. This was because it was asserted by either care managers or care home managers that they would not have understood what was going on and it would not have been ethical. Having observed the older people in review settings it seemed to me that these assertions were well founded. However, the other three older people interviewed were able to give their verbal and written consent and any communication difficulties, for example, through physical, sensory or mental impairment were not significant.

Holstein and Gubrium (2004) argue that no interview ever yields up a 'true' picture of 'reality'. Consequently, not only because of the philosophical but also the various social, technical and practical challenges involved, I decided to be as reflexive as a researcher as possible (May, 1999). In taking this approach I would necessarily need to include examination of my own biases and values that would influence any

interpretations made. In this way I could ensure that every field encounter could be learned from in some way without necessarily believing that the 'truth' had been found in any of them.

## **Documentary data sources**

The third source of data comprised the paper and electronic documentation related to the review system in the County. This was not just the forms written up by the care managers after the review, but also organizational guidelines, reports and other material available online or in hard copy. It was important to collect this data because, as Atkinson and Coffey (2004) explain:

...qualitative field research should pay careful attention to the collection and analysis of documentary realities. Such enquiry is not confined just to the inspection of documents themselves [.....] It must also incorporate a clear understanding of how documents are produced, circulated, read, stored and used for a wide variety of purposes (p.58).

The case study encompassed the work of statutory social care teams and regulated care providers. It was therefore expected that those working within the review system worked to, interpreted and generated different 'paperwork'; typically in the form of guidelines, reports and case records. Therefore, the case study needed to include these as relevant 'naturally occurring' data. I was particularly interested in examining how the reviewer 'wrote up', or represented the 'reality' of the review and translated it in to action. According to Atkinson and Coffey (2004):

...texts are constructed according to conventions that are themselves part of a documentary reality (p.73).

In terms of what can be gained from their analysis, Ritchie (2003) explains that:

Documentary analysis involves the study of existing documents, either to understand their substantive content or to illuminate deeper meanings which may be revealed by their style and coverage (p.35).

Therefore, documentary data can be analysed in different ways: for their formal properties, for the language used, and for their rhetorical features.

Although not fully anticipated at the start, time in the field also produced other 'unwitting' forms (Robson, 2002) of textual data that illuminated how aspects of social care system were working. Specifically, Internet communication (e-mail) featured significantly in access negotiations to the point that it was decided, opportunistically, to incorporate this data for analysis (see Chapter Nine). This highlights that, in the early 21<sup>st</sup> century, understanding of 'the field' must include consideration of what takes place in cyberspace (Wittel, 2000). Markham (2004) cautions that analysis of such exchanges requires sensitivity to the fact that Internet communications have their own conventions and there are theoretical, practical and, even ethical, concerns raised by the use of such data sources. However, if the aim was to produce a case study that was holistic, in-depth and fine grained (Wittel, 2000); to omit this data would not only have left out important insights, but also risked producing an impoverished account of time spent in the field.

This section has outlined the methods adopted in order to generate the appropriate data for better understanding both the purpose and function of statutory care home

reviews. It has acknowledged that ideas about the purpose and experiences of reviews vary according to the perspective of where one is situated within the system. This confirms that this study involves capturing multiple, potentially competing, *realities* rather than a single reality. This important point requires a more explicit discussion of the ontological and epistemological assumptions underpinning the study.

## **Ontological and epistemological assumptions**

Earlier in this chapter, when discussing the challenges of 'triangulation', I said that I had adopted a 'social constructionist' ontology. According to Blaikie (2010):

Ontological assumptions are concerned with the nature of social reality. These assumptions make claims about what kinds of social phenomena do or can exist, the conditions of their existence, and the ways in which they are related (p.92.)

The ontological approach underpinning this study has variously been described in the qualitative research literature as 'idealist' (Snape and Spencer, 2003; Blaikie, 2007), 'anti-foundationalist' (Grix, 2004) and 'constructivist' (Bryman, 2004) in that it is believed that an 'objective' reality is unavailable to us. Instead, it is held that reality is socially constructed and that social phenomena do not exist independent of human actors. Different versions of reality are constructed through the interactions of human actors which do not necessarily correspond with each other (Harré and Krausz, 1996). Therefore, the ontological position which has informed this study is 'relativist' and is succinctly encapsulated by Denzin and Lincoln (2005) who state:

There are no objective observations, only observations socially situated in the worlds of-and between-the observer and the observed. Subjects, or individuals, are seldom able to give full explanations of their actions or intentions; all they can offer are accounts, or stories, about what they have done and why. No single method can grasp all the subtle variations in ongoing human experience. Consequently, qualitative researchers deploy a wide range of interconnected interpretive methods, always seeking better ways to make more understandable the worlds of experience they have studied (p. 21).

Epistemological questions concern how we know what we know and whether what we know is 'true' (Gomm, 2009:114). Following from the ontological assumptions outlined, the epistemological position is informed by the belief that there is no single objective reality available to the researcher. This aligns with a 'social constructionist' stance, where social constructionism:

....is the outcome of people having to make sense of their encounters with the physical world and with other people (Blaikie, 2007: 32).

It could equally be said to align with an 'interpretivist' epistemology where:

Facts and values are not distinct and findings are inevitably influenced by the researcher's perspective and values, thus making it impossible to conduct objective, value free research, although the researcher can declare and be transparent about his or her assumptions (Snape and Spencer, 2003: 17).

I therefore propose that, in this case, an interpretivist epistemology is congruent with an idealist ontology and that this is how the 'reality' (or 'realities') of the statutory



review system will be understood and presented. Given the 'interpretivist' approach I have adopted, it is important to reflect further upon my own personal and professional 'situatedness' in relation to the field.

## **My relationship to the field as researcher**

Smith (1998) states:

....in social science we are both the subject and object of our own knowledge. When we study social life we are also studying ourselves' (p. 7).

This highlights the need to both reflect on and be aware of how the researcher's 'biographical situatedness' affects both the researcher themselves and the field they are studying throughout the research process (Denzin and Lincoln, 2005). Denzin and Lincoln state that:

Any gaze is always filtered through the lenses of language, gender, social class, race, and ethnicity. There are no objective observations, only observations socially situated in the worlds of-and between-the observer and the observed (2005: 21).

Therefore, it would be wrong to pretend that one arrives in the field *ex nusquam*, unencumbered and detached. It is important to consider how the different dimensions of one's 'biographical situatedness' may affect the research and vice versa. It is a complex and dynamic interrelationship. However, whether a researcher can make anything other than plausible interpretations about how this might impact is debatable. For example, the research sensibility I brought to the field was shaped by a mixture of values, knowledge and experience derived from personal history,

experience from previous and current job roles and from academic study. It is useful to identify (both to oneself and to others) key features that might have a bearing.

### **Professional dimensions**

I am a former social worker who has worked in the County in different settings since 1984. Early in my career I worked in a 'generic' social work team and part of that role involved arranged care home admissions for older people and reviewing their placements. This work took place before the community care reforms of the 1990s were implemented. Another setting was as a part-time social worker in an older person's team. This was after the community care reforms and, although my role was primarily on duty, I was involved in some aspects of care management, although not statutory care home reviews. However, I finished in practice in 2003 and started the research in 2006, so there was a reasonable time period for any potential role conflicts to be settled. I have also worked in Further Education in the County which involved training care staff. Therefore, I am known in a variety of roles within the world of adult social care; as a former colleague, as a practitioner, as a social care educator, more latterly as a social work educator and now as a researcher. Whilst this background has been instrumental in shaping my views about adult social care and very useful in identifying the research topic and associated questions, it also underlines the fact that, whilst I no longer work in the field, I cannot claim to be wholly separate from it – there are many personal and professional links.

Role clarification and boundary setting were therefore critical and would need to be ongoing. To some extent the written participant information performed this role, especially as it carried The Open University logo. However, there were instances where it was necessary to remind people what 'hat' I was wearing', for example, when care managers might say to me 'you know what it's like'. For this and other reasons the time in the field needed to be negotiated with a high degree of reflexivity in trying to identify the various filters mediating any appraisal of what was going on.

### **Personal dimensions**

Even though they are inextricably linked, it is important to achieve the correct balance between analysis of the field and analysis of self. Gubrium and Holstein (1997) caution that the post-modern tendency to engage in self-examination can result in the research becoming a 'self-representing enterprise' (p.16).... 'to the detriment of empirical analysis itself (p.15). However, I had experienced the statutory review process as a relative (son) in another local authority. Those experiences clearly made an impression on me – to the point of it being an identifiable factor in deciding to investigate formally the residential care review for doctoral research purposes some years later. One key observation, at that time, was how, despite their best efforts, it was difficult for the reviewer to come in, as a stranger, and to understand fully the older person's circumstances. Another was that the older person (my dad), for a variety of reasons, seemed to be keen to say that everything was fine when, to me, they palpably were not. Lastly, despite several points being raised, the review did not seem to change the home's care practices significantly. However, the reviews in question occurred in 2000, so I would argue that sufficient time had elapsed to be able to reflect on and separate out appropriately the

'personal' from the 'professional', although I acknowledge there are limits in how objective anyone can be about their personal experiences, however much time elapses.

The research does not pretend to be value free, subjectivities play a part. It therefore becomes important to ensure that the subsequent analysis and interpretation is always clearly grounded in the data and that the analytical practices used to make any inferences are as transparent as possible.

## **Conclusion**

In this chapter I have explained the goals of the research, given full consideration to ethical dimensions and discussed critically the methodology underpinning the study. In doing so I have also located the study in the social constructionist tradition of qualitative social research. This is a tradition which recognises that social reality is constructed around the subjective and intersubjective interpretations of different social actors. The following three chapters are devoted to the presentation of empirical findings from the field work. Here, what was observed in three care reviews; the various actors' practices and behaviour together with their subjective interpretations of the care home review process are discussed in depth. The presentation of findings and discussion in these chapters therefore greatly assists with answering the first three research objectives in this study. In the following Chapter (Eight) my attention turns to the fourth objective (assessing the relevance of Lipsky) and this forms part of an over-arching discussion of the statutory care home review system.

# **Chapter Five: Making Sense of Reviews in a Context of Change**

## **Introduction**

Chapter Four explained how significant difficulties with accessing and observing actual care home reviews led to the decision to modify the research design from one based predominantly on direct observation of reviews to a case study of the care home review system as a whole. The case study built upon such observational data that could be collected by using additional interview data and documentary evidence from the wider care home review system. Consequently, this is the first of three chapters based on analysis of the data. The first (Chapter Five) provides an overview of how statutory care home review system operated in the County and compares the different perspectives of key stakeholders; the second (Chapter Six) examines the practices observed in three actual reviews in closer detail, and third (Chapter Seven) focuses on the position of the older person.

This chapter draws on interviews with three care managers responsible for care home reviews (CMs), three care home managers (CHMs), two older care home residents (OPs) and two relatives of a resident (Rels). However, as part of widening the data collection process, representatives from different tiers of management in the County: the Development and Policy Manager (DPM); the area manager for planned care (AMPC) a locality team manager (LTM); a senior social worker (SSW) and an

inspector for the care home regulator (CQC<sup>13</sup>) were also interviewed. As explained in Chapter Four a full chronology account of the data collection process can be found in Appendix Three.

This chapter discusses the findings from these interviews to explain the different scheduled and unscheduled reasons why reviews took place: the various interpretations that different stakeholders had of what a review's purpose was, and the impact of the continuously changing policy and organisational context in which care home reviews took place. What emerged from these interviews was that the care home review system was characterised by ambiguity of purpose, compromise and, consequently, conflict both *between* and *within* those trying to make the system work. Such conflict inevitably created tensions that had to be resolved in some way. The findings discussed in this chapter provide a context to better understand the role played by 'de facto' discretion in managing the pressures and resolving the tensions in the system, which forms the basis for the discussion in Chapter Eight.

### **Scheduled and unscheduled reasons for reviews**

As explained in Chapter Two, official guidance sets out a number of different purposes to reviewing the circumstances of older people supported by Local Authorities which include: reviewing the care plan, reassessing the person's needs, reappraising eligibility for assistance, revising the care plan accordingly and recalculating any costs. In general, the interviews confirmed that most of these

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<sup>13</sup> As explained in Chapter Two, the care regulator changed from CSCI to CQC in 2009.

official purposes were understood, for example the locality team manager (LTM) I interviewed explained:

LTM:.....so we would always try and review somebody after six weeks, six to eight weeks to see how the placement was going, how it was working out or not, whether something needed changing, whether it was meeting needs.

In this instance 'after six weeks' referred to one of two types of 'scheduled' review that applied to all placements – 'initial' and 'annual'. The need for these two types of scheduled review was indicated in policy guidance (see for example, Department of Health, 2002b) and this was commonly understood amongst all those interviewed. However, there were also 'unscheduled' reviews which arose from the specific circumstances of a particular placement. In these situations, whether a review was required and for what reason appeared to be a matter of interpretation by different stakeholders in the system. Whether scheduled or unscheduled, reviews created points of potential conflict between stakeholders for different reasons.

## **Scheduled**

### ***Initial reviews***

The 'initial review' was meant to take place a short time after an older person's admission to the care home. By its nature, this was the most common form of review. Some people referred to this as the 'six week' review, but no such timescale was laid down in either national or local policy guidance. Initial reviews following hospital discharge appeared to be particularly problematic. Such problems were often to do with the transfer of responsibilities from the hospital team to the locality

team. One care manager (CM3), for example, thought that these reviews were getting 'a bit lost'. This was supported by all three care home managers interviewed who expressed views that the system did not always appear to join up very well in this respect. For example:

CHM1: Yes, they have a six week review. .... We had a lady from the hospital.....I actually contacted the call centre<sup>14</sup>, and said, I'd like to request a review for this lady.

I: Yeah

CHM1: And I subsequently heard that the six week reviews have not been or the paperwork's not being passed on very quickly from discharge planning...

I: To the locality team?

CHM1: So, to the locality teams, so that's having a bit of a 'knock on effect' on the sort of timing of these initial reviews.

This comment, particularly, the reference to having to contact the 'call centre' illustrated the fact that communication between key stakeholders around the older person's initial review (essentially getting hold of the right person) was not always straightforward. More often than not, residents of care homes did not have named care managers allocated to them, meaning that in order to discuss their case with the relevant locality team, care home managers had to, first, contact the 'call centre'. This extra stage in the line of communication appeared to present another source of potential tension between parties, particularly when what was perceived as unacceptable delay was involved.

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<sup>14</sup> The 'call centre' refers to the County Council's Contact Centre, discussed later in Chapter Eight, which took over all contacts about and referrals for adult social care in May 2003.



## **Annual reviews**

The 'annual review', as the name suggested, was meant to take place after the older person's placement had been running for twelve months and, thereafter, annually.

Annual reviews also occasionally created tensions between care homes and the locality teams, with inconsistency, disorganisation and, at times, a failure to complete them at all, appearing to be the main sources of complaint, mainly by care home managers. As one said:

CHM3: It's more that's it's not happening than it is happening

Other care home managers talked about problems with receiving the necessary paperwork and also with reviews being set up with insufficient notice being given.

Relatives interviewed saw the annual review mainly as a legal necessity. For example:

Rel 1: .....Because as we said earlier, we didn't request the meeting, it's something that seems to have to come up, that has to be done

Rel 2: It's the law.

The relatives expressed the view that if there were important issues, they needed to be dealt with at the time and not wait for an annual review to take place. Therefore, whilst, for some, tensions were experienced because of the way the system was organised, for others the fact of being asked to attend a review in the first place was a source of potential frustration in itself.

## Unscheduled reviews

Reviews took place for reasons other than those outlined above. For example, outside of both the 'initial' and 'annual' review, a review could be instigated by a care home or relative if they felt that a resident's needs had 'deteriorated' and they either wanted them to be moved or wanted to secure additional funding in order to have the older person's needs better met. For example:

CHM2: ...because we don't actually have full registration for people with dementia, if someone becomes, or develops behaviour problems, we're not supposed to be looking after them here.

I: Right

CHM2: So I have to then try and get a review

I: Yeah. Would that be the most common reason?

CHM2: When there's been a deterioration, sometimes we'll just phone the social worker and say, you know just want to let you know this person's really poorly now and so we're in the loop and we've let the family know. Other times, when it's behaviour issues, then we need them seen because they might need to be moved on.

I: Yeah. Do you ever get relatives or anyone else initiating a review?

CHM2: Yes, yeah, very, very, occasionally but usually if they're unhappy with the care.

An older person could not be moved without a review, therefore, in circumstances where a care home felt they could not cope with an older person, the review became a meeting with potentially very significant consequences. The longer the period before a review took place, the greater the tension experienced by the home and,

potentially, the greater the discomfort felt by the older person and those around them. One such example was found at one of the care homes researched:

CHM3: I have a situation which I have now, where I've to beg for somebody to come out and still having to wait how many weeks after I requested a visit or review.....

CHM3: I said to you before, there's one pathetic case where a lady came in 2007<sup>15</sup> already and still have no reviews at all. None, which is critical for her to have, because her needs have deteriorated. Because she hasn't had one since 2007, clearly has deteriorated, we've involved other professionals to help us to cope with the lady. Now we've come to the end of the road where the professionals are saying 'no you can't cope any more. You can't do anything more than what you are doing. She needs to go to a different place'.

A review could therefore be instigated to create change. In this case, the review was seen as instrumental in bringing about a course of action desired by the care home.

As indicated by CHM3, reviews were also triggered by relatives for different reasons. The SSW provided an example where a review was required in order to move a local authority funded resident to a care home in another county. It became a complex situation and highlighted another function of reviews – as a means of resolving complaints. The relatives had originally wanted their mother to transfer to a care home in a county nearer to where they lived. This triggered a review because the County retained the responsibility to fund the placement and needed to confirm the level at which it should be funded. It transpired that the review indicated that the

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<sup>15</sup> This interview took place in June 2010.

resident had only 'residential' needs. The relatives were under the impression that the older person was already occupying a 'nursing' bed and that was what they had found for her in their own county. Disappointed with the outcome, the relatives demanded a second review following a complaint.

SSW: the complaints system came into action because the family were clearly unhappy because the worker who did the review sent the necessary information to the purchasing panel because she was aware that there was a shortfall for funding the home identified.

In this case, it was said to be complicated by the fact that there was a disagreement among professionals about the exact nature of the older person's needs. The GP thought she required nursing but the District Nurse<sup>16</sup> thought that only a residential placement was necessary. This illustrated that although often talked about as a straightforward, bureaucratic, 'tick box' exercise; statutory care home reviews could, on occasion, become highly contested exercises with significant implications in terms of finance and levels of care provided.

Unscheduled reviews could therefore take place for a variety of reasons and illustrated that different stakeholders could initiate and approach specific reviews with quite different agendas.

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<sup>16</sup> Since 2001, people receiving nursing care in a care home have been entitled to additional funding (the registered nursing care contribution). Only a qualified nurse can make this assessment.

## **Ambiguity about purpose: diverse interpretations**

Arguably, whether scheduled or unscheduled and whatever the motives of different stakeholders in instigating them, the purpose of reviews was still, basically, about establishing whether the placement met the needs of the older person. Such a purpose could easily be found in official guidance. However, in the interviews, in response to the question of why reviews took place, a variety of interpretations as to their 'real' purpose emerged, beyond those found in official guidance. It was possible to group these alternative interpretations under three broad headings (see below). However, the evident ambiguity about purpose helps to explain how the exercise of discretion was both possible and necessary in practice.

### **'Just a statistical thing'**

All three care managers interviewed were well aware of the need to complete reviews in order to meet performance targets. For example, according to one care manager, reviews were:

CM1: Just a statistical thing that's got to be done and shown to be done

This care manager expressed a degree of cynicism about whether, for 'management', there was any real purpose to reviews beyond making sure they were done:

CM1: They (management) don't care how they're done as long as they're done

The 'pressure' to get through as many reviews as possible per week was strongly felt by the care managers ('we're under pressure to do lots of reviews': CM3). There were concerns expressed about the effects this would have on practice.

CM1: With all this pressure to do all this amount of reviews in a week (at least ten)

...the standard would have to be lowered to get them done.

Amongst both managers and practitioners, it was not difficult to find evidence of the pressure to meet targets on numbers. However, what the actual targets were and who actually checked whether they were being met proved harder to establish.

Aware of the need to demonstrate productivity, the LTM had imposed on her own team a target of 10 - 15 reviews per week (which was backed up by a poster on the team notice board). The LTM was clearly aware of how other teams were performing in this respect:

LTM: you've come at a time when, we're rapidly trying to catch up and demonstrate the work done. And it's very frustrating for me because other teams have pulled [their team] down if you want.

The LTM's belief was that while her team's statistics on completed reviews were good, other teams' less impressive figures were making the County's overall figures look bad. However, despite this comment, there were no organisation-wide figures published and there were no centrally handed down targets for each team.

Therefore, a great deal of the LTM's desire to increase throughput was down to her own personal productivity drive. The Senior Social Worker interviewed, who worked in a different team, was less clear about any targets on reviews whether decided at organisational or team level.

I: Is there an expectation of how many reviews will be carried out in a week by a review person?

SSW: I would like to think there is but I don't oversee all the reviews, I mean the workers that I oversee do reviews but, there is an expectation, but I don't know what the formula is.

This illustrated how, in the absence of any clear guidance from higher up the organisation, an individual manager made their own interpretation about organisational priorities and guided their team's performance accordingly.

### **Upholding 'human rights'**

The need to complete reviews in order to meet certain performance indicators was widely accepted in the organisation. However, care managers also constructed meanings about the purpose of reviewing care home placements from their own personal and professional values. For example, CM1 said it was about 'if someone's human rights are being upheld'. CM2 talked about the review function as being about checking that the older person was 'free from hunger', 'out of pain', 'comfortable' and being 'treated with kindness'. CM1 also believed that the purpose of a review was to ensure that residents were 'happy with everything', which was also a term also used by CM3. Ensuring that the older person had 'choice' was also an important function for all three care managers. In circumstances where there was a pre-existing relationship with the older person, CM2 believed a review was 'a formal way of ending your involvement' – by which he meant his own involvement as case holder over the preceding months - which is not a function listed in guidance, but in acknowledging the importance of relationships illustrated the application of social work values to a bureaucratic process.

## Value for money

Checking and recalculating costs are part of a review's officially stated purpose. However, when interviewed, managers and practitioners did not talk explicitly about the financial aspect of care home reviews in the sense of identifying whether the County was getting value for money from service providers. By contrast, those stakeholders interviewed who worked *outside* of the County organisation, for example, providers and inspectors, were only too aware of that particular review purpose. For example, one care home manager said:

CHM2 I think they're [reviews] a good idea because I think anybody who's funding a bed is going to want to know whether that person is being looked after in the correct way.

And, according to a local Care Quality Commission inspector (CQC), the care plan was essentially a 'contract to provide services' and therefore:

CQC: I also think you can look at it as a business transaction. In fact, you should do. The not inconsiderable sum of £400 or so a week is being paid, to someone to do certain things, things that should be clearly written down in the care plan and updated. Basically, it's a contract. I'd want to see that a service user is not only involved in the process but that it is seen to belong to the person whose place it is. It's a like a contract which the service provider has to deliver on and to which they can be held accountable.

CQC conceived of the care plan as a business contract and, therefore, the review became the means by which consumer rights were upheld and the service provider



held to account. However, in their experience, CQC was doubtful whether the statutory review, in its current format, was fit for that purpose. Describing it as 'not much of a review' they thought it mainly a tick box exercise.

The existence of such varying views about what reviews were for, highlighted the challenges for managers and practitioners in striking a satisfactory balance between the quantity of reviews carried out over a given period and achieving work of a certain quality in the process.

### **Balancing quality and quantity**

How achieving a balance between quantity and quality was articulated and achieved varied between different managers and different practitioners. Three social care managers from the County were interviewed about their views on the review system. In order of seniority they were: the Development and Policy Manager, a locality team manager<sup>17</sup> and a senior social worker. An outline of the key roles and responsibilities of key managers in the County together with their positions in the organisational hierarchy is provided in Appendix 3. Managerial perspectives varied according to their different responsibilities in the organisation and, particularly, in relation to how close they were to front-line practice.

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<sup>17</sup> Although not originally planned, during the interview with the Locality team Manager we were joined for part of the interview by the Area Manager for Planned Care (AMPC) whose comments were mainly to do with broader financial and organisational issues.

## The Development and Policy Manager

The Development and Policy Manager (DPM), was the most senior manager interviewed. Amongst, other responsibilities, she was responsible for 'quality' of practice. This meant, for example, writing operational guidelines and ensuring appropriate staff development training took place in order that practitioners were aware of their roles and responsibilities. She felt that the need 'to trigger certain performance indicators' inevitably meant some compromises on quality:

DPM: There is no getting away from it and no making it pretty, these are the things...

It was therefore evident, albeit couched in apologetic terms, that the DPM was only too aware of the criteria by which she, and the County, was judged. However, having identified this key organisational driver, the DPM was reluctant to simply cast reviews in terms of meeting performance targets. She attempted to clarify her position in ways which encompassed adult social care policy agendas that emphasised person-centredness and user involvement:

DPM: It was a bit of a personal observation. We were kind of underestimating a lot of the review, I felt, in the County. So when the review officers were going out it was becoming too much of a *tick box exercise*, so within the new training that went out with all of this *it was about user view*, the officer's responsibility to check the care plan in the homes, check that the information that you've got before you're going out – so what are you reviewing? *Conversations*, you need to go and look at the outcomes about what somebody wanted to achieve....

'Conversation' was a term used several times during this interview. It appeared that for the DPM, given the need to meet bureaucratic targets, this was an important means by which the review system could be personalised around the 'user view', thus achieving a balance of sorts between the two imperatives (person-centredness and meeting targets).

As the interview came to a conclusion, the DPM clearly wanted to resolve some of the ambiguity and 'sum up' her position on reviews and the position of the County in a sentence:

DPM: It is getting the balance between the need of the bureaucracy and the PIs [performance indicators] and also making it meaningful for the individual. You know the whole purpose of the review is, for me it's a key function... *[tails off]*

The sentence was not completed and tailed off into silence without actually explaining what 'the whole purpose was' suggesting there was no single 'whole purpose'. The DPM identified at least two – which were in potential conflict with each other. It was thus an 'unfinishable' sentence and illustrated perfectly the position in which a senior manager like the DPM found themselves – having to reconcile divergent agendas and to 'manage' the tensions therein. She struggled to explain this verbally, which raised the question of how this balancing act was achieved in practice.

## **The Locality Team Manager**

Unlike the DPM, whose role was more strategic, the Locality Team Manager (LTM) line managed a team of care managers and was, therefore, only one stage removed from practice. As with the DPM, for the LTM the purpose of conducting reviews was framed in terms of achieving a balance. LTM's interview comment that 'I have to balance quality and quantity' encapsulated well how she had to combine maintaining the quality of practice within her team with making sure that the team managed a certain 'throughput' of work every week. It subsequently emerged which of the competing managerial imperatives had priority for her.

LTM: .....one of the purposes of reviews is that we have to, no it's the other way round really, we have to demonstrate our work against a performance framework for the government. So, you've come at a time when, we're rapidly trying to catch up and demonstrate the work done.

The priority for the LTM was that reviews were carried out in order to meet quantitative performance targets. This meant that certain compromises on quality had to be made.

LTM: Our review worker, here, gets through more reviews than anybody else in the county and her review paperwork can be extremely thin and there will come a point when I'll pull her up on it, but I have to balance that because I have to get the numbers through.

At her level of management, LTM was acutely aware of having 'to get the numbers through'. Whereas the more senior DPM's expectations of review practice were about looking at a service user's aspirations ('you need to go and look at the

outcomes about what somebody wanted to achieve'), conscious of the need to get through the work, the LTM's views on reviews appeared to be more pragmatic and about doing no more than was necessary.

LTM: So, as long as they're checking it, even if it's a tick box, and we don't capture all the conversation, if they're looking at what they need to do, then perhaps we have to be satisfied with that. I'd prefer a balance but I think reviews have got more onerous and more important as our partner agencies do less and less.

Here, the reference to 'our partner agencies' doing 'less and less' referred specifically to the care regulator who, in the LTM's view, were reducing their inspections of care providers leaving local teams to take more responsibility for the quality of care provision. The relationship between the regulator and the team appeared to be quite remote. The realisation that teams were taking more of a 'policing' role added to the tensions as they tried to maintain a high turnover of work to meet performance indicators.

LTM: If we have to meet performance indicators, if we have to keep things moving along and we have to manage people's time – not just the review officer, somebody has to read all that. If I've got a flavour of what went on and the right outcomes for that service user, if I've captured what needs to be done, the action points, if I've captured controversy and everybody's views in one line – why do I need twenty lines?

In this environment, the LTM highlighted both the pressure they were under and therefore the importance of the practitioner's 'professional judgement' in how much work should be put into each review.

LTM: .... I don't have that time, the care manager doesn't have that time and, at the end of the day, maybe ten, twenty reviews<sup>18</sup> that week, only one of them will need that amount of input and as long as they get where it's needed, that's fine

I: Yes

LTM: Professional judgement I think

Therefore, the picture that emerged was that, in order to meet performance indicators, the LTM said she needed only to get 'a flavour of what went on' in the review. This illustrated a paradox of performance management when operating under such conditions. In order to 'get the numbers through' and to 'keep things moving along', the LTM settled for a very minimal method of review recording - 'a tick box' plus 'one line'. This was an effective means of ensuring practitioner discipline as far as the *pace* of work was concerned but such a compromise meant that the LTM yielded a significant degree of managerial supervision and control over all other aspects of the review process. While the DPM expected 'conversations', the LTM's managerial approach indicated little curiosity about what review practices were like and, significantly, little curiosity about who the older person was. From the care manager interviews, it was possible to gain a practitioner's perspective on this managerial style. In talking through the stages of the review process, one care manager explained that, once their side of the paperwork was 'done':

CM3: I give it to my supervisors to sign off, whether they read my reviews or not, I don't know.

I: OK – have you ever had anyone pick up on the content...?

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<sup>18</sup> It was interesting to note that the figure of twenty reviews (not all of residential care) per week far exceeds the target number displayed on the team notice board referred to earlier.

CM3: No. I suspect in the scheme of things. We would discuss cases in supervision, so if I went to do a review on somebody, and I felt there were issues, then I would share that information, the same as if I went and there were issues about the placement not being right or if there were particular issues about the quality of the care, then I would be discussing that with somebody, so I think unless, I would say with (*supervisor's name*), unless I've gone to her and said 'I'm really worried about this'....

This not only provided an insight into the relative preoccupations of manager and practitioner in this case but also an insight into way the manager-practitioner relationship operated. At the point of 'signing off', the key issue seemed to be simply that the review was 'completed'. CM3's comment 'whether they read my reviews or not, I don't know' created a picture of a managerial preoccupation with tick box targets and little else – unless issues happened to be raised by the practitioner.

### **Senior Social Worker**

Occupying the most junior management position in the adult social care system, directly below the team manager, was the senior social worker (SSW). She carried out some reviews herself but she was also delegated certain managerial/supervisory responsibilities in respect of care managers in the team. There was therefore a degree of overlap between her responsibilities and those of the LTM. For example, they both performed the role of checking and signing off the review paperwork. As the SSW explained:

SSW: Cases are signed off by senior workers and checked out. You know, there is a kind of safety net to kind of go through files and check that the work has been completed and that everything has been done as it should have been.

When the SSW said that she checked 'everything has been done as it should have been', it only referred to *whether* the task had been completed not *how* it was completed. 'The safety net' referred to was very much a checklist approach based on tasks completed rather than an examination of the quality of practice. However, within the SSW's experience, even this management role appeared to be undertaken inconsistently.

I: Have you got anything to say about how easy or difficult it is for managers to....As they have to sign off a review, don't they, what about that part of it, how well scrutinised are reviews in general?

SSW: That's a tricky question. I personally, we have to sign files off, but I can tell you that some files don't get scrutinised, I can give you lots of, because I'm in a position where I see these things now, and I'm actually appalled by some of it.

The SSW's feelings came from the experience of finding instances of tasks left undone or incomplete when checking files. The picture that emerged was that, even without the scrutiny of the paperwork, let alone the actual practice, any idea that tight managerial control was exercised over practice in such instances would be misplaced. In such conditions, the 'performance' of the team would have mainly been measured by numerical targets.

I: Well, let me just ask you ... in general terms, how is it for a supervisor or a manager to really have a sense of the quality of the review how easy is it for a supervisor or a manager to really get a good feel of the quality of the work and what's been carried out from the paperwork?



SSW: I think, basically, you work in a relationship and how open and honest the worker feels that they can be and I guess how much support they feel they're going to get from you as well in resolving issues. But you've got to take the worker at face value and the recording, as you sign the cases off, you can have a discussion in supervision about the case, or hopefully, issues will be highlighted there. And there's got to be conclusion to these issues which hopefully, when you're signing reviews off, you should be fully aware of that.

I: A lot of it can't be deduced from the paperwork? You say it's this relationship between the manager and the worker?

SSW: It's a trust thing isn't it? You do have to trust what the worker is telling you.

I: Yeah, so as we said earlier, practices can therefore vary?

SSW: Greatly. They do vary a lot.

A care manager's direct practice with service users, being unobserved by managers, inevitably enabled them to exercise a high degree of discretion both in terms of what they did and what they reported that they did. From the SSW's perspective, being responsible for review quality whilst having, at best, only a partial picture of what was actually going on in practice, was a source of tension. She appeared to manage any misgivings about practice with pragmatism – 'You do have to trust what the worker is telling you'. Whether the trust was always genuine and whether that trust, genuine or not, was always repaid by the practitioner, was not known.

## **The telephone review: epitomising the compromises in review practice**

Reconciling the need to do the work quickly in order to meet organisational goals with the need to achieve more professionally-motivated goals such as upholding rights or ensuring choice called for compromises in review practice. The ultimate in such compromises seemed to be illustrated by the telephone review. The tensions and compromises around this form of review were appreciated throughout the organisation. The Development and Policy Manager provided a senior management perspective:

DPM: There was never any, there was never any guidance or instructions around, certainly doing telephone reviews, letter reviews, out of county reviews. There is now.

I: Is there?

DPM: I have put that in now. And I've tried to put it in with a bit of quality around it, if you can put quality in a telephone review. You can say that a telephone review is better than no review which was unfortunately happening...

However, further down the organisational hierarchy, the potential for putting 'quality' in any kind of review, let alone the telephone variety, seemed extremely limited:

SSW: What you often find is, often the reviews are done, quite often in isolation – with no key worker, no manager from the home, sometimes family members. It's sometime not a thorough review, and more and more, we're being asked to do reviews via the telephone.

Exactly how a telephone review was carried out was purely a matter of practitioner discretion. The most minimal approach reported was a single phone call to the care home (not necessarily speaking to the older person) but it could also include other stakeholders such as relatives. However many telephone calls were made, this review format inevitably raised concerns about obtaining any meaningful involvement from the older person. For example, CM1 highlighted certain specific limitations in how well she could do her job via the telephone

CM1: My major concerns with telephone reviews are 90% of the people you speak to probably have a hearing impairment.....plus I can't look around where they're living.

There were, therefore, several flaws acknowledged by both managers and practitioners with this form of review practice. It was not possible to get figures on how many telephone reviews were being carried out. However, they clearly took place and illustrated well the compromises and trade-offs that were being made in the statutory care home review system in order to meet diverse review purposes. The need to compromise did not always sit comfortably with care managers' professional values, leaving them troubled about the possibility that the system was, at times, exposing extremely vulnerable service users to risk. As one care manager asked graphically:

CM2: How much more marginalised can you get? Than being in a little room, shared room even, in a nursing home, tucked away somewhere in XXX Road? How much more marginalised can you get? You know, you know, who's .... you're at the mercy..

Despite the various qualms expressed about their fitness for purpose, the persistence of telephone reviews illustrated well the intense pressures to compromise practice in order to get through a certain volume of reviews. The tensions around achieving an acceptable balance between the quality and quantity were not confined to those at the front line. Such tensions appeared to be felt as acutely through all tiers of management in the County's organisational hierarchy. The ambiguity about what reviews were for and how they should be conducted also raised questions about the degree of control over practice available to those responsible for managing the County's review system.

### **The challenges of achieving a balance: the managers compared.**

There appeared to be some subtle differences in the supervisory relationship described by the SSW and the LTM. This might have been because the LTM's role was that of manager only, whilst the SSW's role straddled both management and practice. Her role not only encompassed staff supervision but she also held and worked on cases. In that respect she was one of team. Because of her greater proximity to practice, both the tensions inside her and the tensions between her and those whom she supervised were, perhaps, felt most acutely and expressed all the more graphically in the interview. Unlike the LTM, the SSW was more likely to initiate discussions about practice issues *before* signing off reviews. Less was taken for granted. However, despite saying that 'you've got to take the worker at face value', she was only too aware that this approach was risky because of how practice could vary, a point she returned to later and which drew attention to some of the latent antagonism that existed between management and workers.

SSW: And you'd hear workers whinging about their supervisors and, you think when I am where I am now, I can understand and appreciate because some of the workers don't do a really good job.

Therefore, when it came to supervision of review practice, both the LTM and the SSW were placed in positions where they felt that a significant degree of compromise was necessary in order to keep the review system going. On one level they were aware that the quality of review practice varied (at times to the level of being 'appalled' by it), but, there were obvious limitations on either what they could do or were prepared to do about it. Somewhat paradoxically, but possibly reflecting her relatively junior role, the SSW seemed to be less prepared to let variable practices go unchallenged, usually by confronting practitioners directly in supervision.

The tension that all three managers felt in respect of the need to balance quantity and quality was intensified by the need largely to trust practitioners on quality matters, whilst knowing from first-hand experience that review practice was actually very variable.

All three managers had to balance the need to get the work done in order to meet the organisation's performance targets with the need to ensure that the work adhered to certain standards of quality laid down in policy guidance. It was apparent that the closer to practice the manager, the less aspirational, the more pragmatic and even cynical they appeared to be about the possibility of actually achieving this balance satisfactorily. Whether review practice was of any 'quality' was something

largely taken on trust. The compromise on practice seemed to be felt more acutely and expressed with increasing degrees of candour the nearer one got to the front-line and encounters with actual service users.

The need to find a compromise between quantity and quality created tensions within the system which were felt by managers and practitioners at every level. However, the challenge of resolving the ambiguities inherent in the review system was intensified for those working within it by the fact that, for various reasons, the wider system of adult social care in the County was undergoing continual change and this, inevitably impacted on the care home review system in different ways.

### **A context of constant change**

As described in Chapter Two, the broader adult social care system in the County was undergoing continual changes brought about by a combination of national policy developments and local factors. It became apparent that the impact of certain changes – for example, those designed to improve efficiency - increased the pressure on managers and practitioners trying to make it work. However, the nature of the policy directives also intensified the tensions around reviews by adding to the ambiguity around the goals of the adults social care system – for example, facilitating self-directed support or safeguarding vulnerable people

### **Local reorganisations, financial pressures and the need for efficiencies**

As outlined in Chapter Two, the reorganisation of the County adult social care services in 2006 created 'new business units'. It appeared that this had some impact on how reviews were carried out.

AMPC: So that's changed the structure of the teams quite dramatically as well, we're having to think more area wide for efficiency purposes as well. So that's why we're reviewing the whole review process and trying to make sure that we don't get into this having to sprint towards the end of the financial year to catch up with reviews.

The reference to having to 'catch up' with reviews illustrated how the pace of the team's work seemed to be governed by where the team was in relation to the end of the financial year, by which time certain targets had to be met. However, perhaps a more important point in this case was that, against a background of constrained resources, the older people's social care teams had undergone two major organisational changes in quick succession, both of which appeared to be guided, to some extent, by the requirement to make 'efficiencies'. Equally important was the point, highlighted in Chapter Two (and discussed further in Chapter Nine), that successive restructurings had caused a considerable degree of staff turnover and staff redeployment, particularly at management level, which had appeared to disrupt the running of the organisation in various ways. It was also explained how, in addition to adapting to new organisational systems, social care staff in the County had to adapt to several major new policy changes introduced over the same period. The specific impact that each policy initiative had on care home reviews appeared to vary.

### **The impact of 'personalisation' and self-directed support**

Although aware of its importance to adult social care more generally, it was not always apparent to those managers and practitioners interviewed how the

personalisation agenda would specifically affect care homes and care home review work.

I: OK, self-directed support – I'm making – possibly the wrong, assumption, that it doesn't really apply in the same way to people in care homes?

DPM: It's, it's again, this is where, for me, looking at the skills mix, the role of the reviewer is going to be, crucial with self-directed support.

The DPM did not elaborate upon either *why* or *how* the review role was going to be 'crucial', however her comments illustrated the fact that managers were aware that personalisation was a big agenda with which they had to engage. Whilst no one interviewed was that clear about what the effects would be. If anything, it appeared to be more obvious how it would affect domiciliary rather than residential care.

LTM: There's also self-directed support which is going to have a huge effect on our reviews

I: Yes

LTM: It's coming in for domiciliary care first – is it?

AMPC: Yeah, it is and eventually it will get round to residential reviews – that's something you need to be aware of.

Whilst managerial expectations were that personalisation would have a 'huge effect' on reviews and that the role of the reviewer was going to be 'crucial', care managers either made little mention of it and, when they did, expressed a degree of scepticism.



CM2: You know, I went to a course yesterday – individual budgets.

I: Oh

CM2: I'm none the wiser by the way, I've done, you know, a day with it and, I think, I think the government are coming out with a lot of rhetoric....and no additional resources.

The most palpable change to the review system in response to personalisation was, arguably, the language used in the paperwork. This appeared to be accelerated by the critical report of the County by CSCI in 2006, highlighted in Chapter Two. One of the County's responses was actually to revive the post of Development and Policy Manager (DPM), part of whose brief was training and responsibility for recording systems including review paperwork. The DPM had therefore changed the assessment and review forms to reflect the personalisation agenda, for example, by trying to introduce more of 'service-user led' dimension. A tangible expression of this was the changing the language from talking about 'client's needs' to 'service user outcomes'. However, this was another innovation that, apparently, was taking time to be fully implemented.

LTM: Because there is a standard template for reviews and we're now moving towards a more outcome focused framework as recommended by the Commission for Social Care Inspection ..... the review form asks how the placement is meeting those outcomes. And despite the training, in my experience, people aren't actually moving forward and relating the outcomes to the outcomes that were looked for.

It appeared that there was a degree of 'lag' between policy emerging and how quickly managers and practitioners embraced new ways of working. At the time the

research was conducted personalisation had barely begun to be implemented. However, the need for social care staff to become aware of it and its implications was clearly beginning to filter through the organisation with varying degrees of understanding and cynicism. The managers interviewed appeared to think that it would require a more 'service-user directed' approach to care management and, by implication, reviews, although quite what it might involve in practice was yet to become apparent. From the responses from both the managers and the practitioners it appears that it would take some time to be fully understood and embraced.

### **Changing measures of performance**

Several aspects of the system of social care regulation changed significantly over the period of data collection. For example, the 'Performance Assessment Framework' (PAF) for Social Services introduced by the Department of Health in 1999 had set 'the number of existing clients receiving a review during the year' as a performance indicator. However, in 2008, the PAF had been replaced by the 'National Indicator Set'. This was a national policy change and I was interested in discovering how this affected the County specifically:

I: So let me just clarify this – the performance indicator to actually carry out reviews on all care packages, is no longer a performance indicator?

DPM: It is no longer a performance indicator that we're judged on by the DoH

I: So, therefore probably doesn't matter?

DPM: But obviously we still have the duty under the Community Care Act to carry out the annual review, so what the County have done, is we've kept it as one of the back

sort of, best practice performance indicators, so we're not to let it drop, so we can make sure that those annual reviews are being carried out.

It appeared that, whilst the County had had to report statistics on reviews to external bodies as the Department in Health the past, this was no longer the case. The completion of reviews in the County had been made a 'best practice performance indicator', a term which seemed to be local in origin and did not appear in national policy. Therefore, the scrapping of the PAF and the removal of the need to report on reviews at the national level had made no real difference to the fact that performance on reviews was retained as an organisational 'best practice' target by the senior management. DPM thought that this decision was because reviews were required 'under the Community Care Act'. The interesting thing was how little managers and practitioners further down the hierarchy, other than the DPM, understood of this change. As explained earlier, the LTM, for example, introduced her own arbitrary team targets, whilst others believed there were statistical targets without knowing what they were.

Another significant regulatory change, the replacement of CSCI by the Care Quality Commission in 2009 resulted in, amongst other things, a reduction in the number of care home inspections (Parliament, 2011). However prior to that, the LTM had already complained about CSCI not doing enough to monitor care homes properly. It emerged that, partly because of the changes relating to regulation and partly due to the emergence of the adult safeguarding agenda, reviews, in her team, had taken on

an additional purpose. They had started to be used to monitor the overall care quality of certain care homes.

### **The impact of the safeguarding agenda ('POVA')**

During the period of data collection in the County it was common to hear staff use the term 'POVA' which stood for 'Protection of Vulnerable Adults' to mean an adult safeguarding case.

LTM: In light of the home we've recently closed down as a result of the reviews and there's POVA [Protection of Vulnerable Adults] interest there, I'm now seeing more reviews come through, which document that they've checked the care plan, checked the recording, because we put out a special form for reviewing those homes to make sure that all the documentation – because documentation is a particular issue in care homes – and it's come up at least twice this week that care homes don't record as required or sufficiently to document what's actually been occurring. So they are getting cuter, our review officers, on checking documentation in homes, and I have a real issue that we should be required to do that. I think that's CSCI's job and I think it's contracts' job.

To put the LTM's comments in context, a serious case review commissioned by the County's Adult Safeguarding Board into a failing care home had noted that 43 separate statutory reviews of its residents had taken place over the period and that not only had none of them raised any concerns, but there was no proper system in place for the sharing of information between the regulator, the County's contracts monitoring department and the information from individual care reviews. In response, the LTM had instituted a system where certain information from reviews was collated

and shared with the County's contracts department. Since the system had been in operation, other care providers had been suspended. Therefore, when the LTM referred to how a particular home was 'closed down as the result of reviews', it underlined how statutory reviews, in that particular team, had taken on an additional purpose beyond that conceived of in policy.

A care manager from another team commented how, in a context of scarce resources, (annual) statutory reviews in care homes had become downgraded compared to initial assessments. However, she used the likelihood of 'POVA' (safeguarding) case to argue the importance of care home reviews.

CM1: If you've got to choose between giving people care out of that budget that don't have any at all or checking on the care of existing services users, then obviously it's going to be weighted towards giving people care that don't have it that need it now

I: Sure

CM1: By the same token, I can't see it to be cost effective when people are being neglected in homes, the care is very poor and they are then subject to a POVA case, the expense, the input, the stuff that goes on getting someone transferred, then the extra care they're gonna need if they've been neglected and they may not even survive

I: Right

CM1: It's happened, I've seen it happen. So, I don't see it's cost effective and when we are only talking, I'm literally talking cost here.

The recent emergence of the adult safeguarding agenda brought with it the concept of wanting to avoid the 'POVA' case. This eventuality provided CM1 with a reason for giving care home reviews more not less emphasis. Interestingly, mindful of the prevailing organisational climate, CM1 was careful to couch the argument not only in terms of 'POVA' but also 'cost effectiveness'. However, despite its importance, another care manager was less sure about what the new 'POVA' agenda meant in terms of actual practice.

CM2: I think one problem I've got with POVA, one problem, with reference to residential reviews and let's say a POVA issue comes out is that I, no-one's actually explained it to me, what, how we protect people in a meaningful way ..... again, it's never really been explained to me how we protect people.

Therefore, the County social care staff interviewed were aware that adult safeguarding (POVA) had grown as an organisational priority, to the point that, in the LTM's team reviews were being used to close a perceived regulatory gap. However, judging by CM2's comments, the implications of the 'POVA' agenda for other practitioners were still far from clear. It was not only uncertain whether 'POVA' would help elevate the importance of care home reviews, it was also not exactly clear how meeting the challenges presented by 'POVA' should be reflected in such reviews.

### **The Impact of the Mental Capacity Act 2005**

As outlined in Chapter Two, the provisions of the Mental Capacity Act 2005 were beginning to be implemented in the County during the data collection period. Specifically, this meant that an older person's mental capacity now had to be considered before a review took place.

CM3: But it's certainly something I think now with the new Mental Capacity Act, then particularly, around reviews, particularly if it looked as if there were going to be issues around the placement there, you'd be looking at that before you did the review.

Depending on their circumstances (i.e. without friend or family to assist them), the older person judged to lack 'capacity' should have an Independent Mental Capacity Advocate (IMCA) involved in their review. However, quite how the process was meant to work in practice was hard to follow when explained by The Development and Planning Manager:

I: If a person lacks capacity, is there any basic requirement that the care manager has to involve the carer or a relative or an advocate at all?

DPM: Yeah. That, that's absolutely discussed in training that they would, you would hope, and, if it isn't, a capacity assessment is carried out in the first instance, by the previous..., and if the person hasn't got capacity, then, yes, you'd include an advocate. You need an independent advocate or somebody that knows that person well on a daily basis

No one interviewed had ever involved an IMCA in a care home review for an older person who lacked capacity. CM3 indicated that it depended on whether there were 'going to be issues' but it was not always obvious what issues would trigger an IMCA's involvement:

CM2: The IMCA, well, you know they deal with money and medical issues really don't they? You know, they're..

I: That's what I'm hoping to find out

CM2: Yeah, I think so if my memory serves me right, I've done the course.

Whilst the issue of mental capacity had clearly filtered through the organisation, the care managers interviewed had, apparently, yet to fully understand the implications for reviews. The use of IMCAs was not the only new policy development emanating from the Mental Capacity Act 2005. From 2009, Deprivation of Liberty Safeguards (DOLs) had also been introduced to safeguard those who lacked capacity and living in institutions. The locality team manager foresaw the significance for those working in social care.

LTM: 'Deprivation of Liberty Safeguards'

I: ...are we talking about....the Bournemouth case, I think is the background to this isn't it? This idea that people can end up being in situations where they haven't got the capacity to articulate that they want to get out ....

LTM: From April 1<sup>st</sup>, [2009] care managers are going to have to seek authorisation, care home managers are going to have to seek authorisation to be able to keep people in homes. And that's for all the ones that have already got that and this is going to be the biggest thing to hit care homes since ...Noah.

Whilst, this development was said to be the biggest thing 'since Noah'<sup>19</sup>, it was still in its early days and no-one really knew how it was going to work. However, it signalled another aspect of care home reviews that, potentially, required enhanced

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<sup>19</sup> This comment implied that the implementation of this policy would result in a great deal of activity in the County care home system as care home managers sought authorisation to care for residents who lacked capacity. In reality, numbers of applications were much fewer than expected locally and nationally (Community Care, 2011.)



professional judgement about critical issues and thus created another dimension to the role that care managers and managers had to interpret and implement in practice.

## **Conclusion**

The chapter began by describing how statutory care home reviews took place on both a scheduled and unscheduled basis in the County. The first type of scheduled review, 'initial' review, was supposed to take place shortly after an older person's admission to the home to ensure that the placement was appropriate to the older person's needs. The second type of scheduled review, the 'annual' review was supposed to take place annually thereafter, broadly for the same reason. It was discussed how both these types of review carried with them the potential for tension between stakeholders. For example, tensions could arise between care homes and locality teams if initial reviews were not carried out in a timely enough fashion following an older person's admission from hospital and care home staff felt the older person was inappropriately placed. The relevance of annual reviews was also questioned by different stakeholders, for example, by relatives who argued that any issues should be dealt with immediately rather than wait for an annual review. On such occasions, the review could feel more like a bureaucratic obligation than a useful exercise, as will be discussed in more detail in the next chapter.

Reflecting the personal, professional and organisational agendas of certain key stakeholders, it was found that older people's statutory care home reviews also took place on an unscheduled basis. Examples found included: care home managers

requesting reviews if they believed that an older person's condition had deteriorated to the point of needing to be moved; a request by a son and daughter-in-law for their relative to be transferred involved a review and the same situation required a further review in order to resolve a complaint that the older person had been placed in the incorrect funding category. In addition, one locality team manager had instructed her team to use the review as an additional 'safeguarding' check, partly to compensate for perceived failings elsewhere in the system.

Therefore, beyond the initial and annual review, locality teams could exercise their discretion in deciding when to hold a review and what purpose it would serve. However, other stakeholders also had a degree of agency in shaping such decisions. That said, there were no instances found where an older person had initiated a review. Why this might be will be discussed further in Chapter Seven which focuses on the roles played by older people in reviews.

The protean nature of the review system was also underlined by the fact that reviews in the County also took place in a context of ambiguous, often conflicting, policy directives. For example, the need to meet performance targets and deliver efficiencies had to be balanced against the need to deliver on agendas that emphasised person-centred care, the need to assess mental capacity and to safeguard vulnerable adults. To add to the complexity of the challenge, these multiple, often conflicting, goals were expected to be resolved in situations where the older person lacked mental capacity and where there were differences of opinion amongst other key stakeholders about the reasons for the review. Therefore, the

statutory care home review system was characterized by the tensions created by these potentially conflicting policy directives, ambiguous organisational priorities and differing stakeholder perspectives. The picture that emerged was not only of tensions *between* stakeholders, for example between managers and workers, typically, about the pace and nature of the work to be undertaken, but also tensions located *within* individual managers and workers that arose out of the constant need to compromise on practice ideals and settle for manifestly sub-optimal outcomes both for the service users and for the organisation in terms of 'Best Practice'. The fact that both the managers and the practitioners reluctantly admitted that some reviews took place by telephone, despite their obvious shortcomings, epitomised such sub-optimal compromises.

A further complicating factor for both the managers and the practitioners in achieving balance, resolving the tensions and, basically, making the system work satisfactorily for its various stakeholders, was that statutory care home reviews were taking place in a context of almost continual policy, organisational and regulatory change. The cumulative effect of these changes appeared, at times, to create confusion about the care management role and thereby intensify any tensions experienced.

In such circumstances, it was evident that the managers not only tolerated practitioner discretion, they actually expected it – albeit with varying degrees of reluctance. Managerial control over anything other than the actual numbers of reviews conducted was very weak and the managers were aware that the only way in which some kind of balance between 'quantity' and 'quality' could be achieved

was to allow the practitioners to use their 'professional' discretion in making the system work. Thus, it was a managerial assumption that the practitioners would resolve, or at least absorb, the tensions highlighted. The existence of this, at times explicit but often implicit, managerial expectation provided evidence of Lipsky's formulation of how street-level bureaucrats operate and this will be explored through further analysis in Chapter Eight.

Having examined different perspectives from a broad range of review stakeholders in the County, I now focus on care home reviews at the micro-level. Chapter Six looks at three different care home reviews in detail and discusses the findings from direct observation, interviews and the examination of documentary sources. It demonstrates how it was possible to examine more closely how the challenge facing practitioners was expressed verbally and how it was carried out in practice; in other words to compare words and deeds.

## **Chapter Six: Review Practices: Managing Tensions in a Contested Space**

### **Introduction**

As became clear in Chapter Five, care home reviews in the County took place in a policy and organisational context which left their purpose open to multiple interpretations. It was suggested that this created tensions for those responsible for operating the system, for example, in finding acceptable compromises between competing agendas. It was also suggested that such tensions needed to be worked out, in practice, through the exercise of discretion, predominantly but not exclusively, by care managers.

This chapter examines more closely the practice observed in three actual reviews and traces the many opportunities for the use of discretion throughout all stages of the review process and by the various participants. Appendix 3 provides full details of the data collection process, however, to briefly summarise here; the first two observations took place as part of the pilot study in 2007 and the third review observation took place in 2009. Observation 1 took place at The Oaks and involved just the care manager who conducted the review (CM1) and the older person (OP1). It was possible to interview both CM1 and OP1 about the review afterwards. Observation 2 took place at The Cherry Trees and involved the care manager (CM2), the older person who had dementia (OP2), the older person's wife (Mrs OP2) and, at one stage, an assistant manager from the home. It was possible to interview CM2 and, briefly, Mrs OP2 about the review afterwards. However, the care home manager (CHM2) did not respond to my request to interview her. Observation 3 took

place at The Elms and involved the care manager (CM3), the older person who had dementia (OP3), her son (Rel 1) and daughter in law (Rel 2) and the care home manager (CHM3). It was possible to interview all of the participants except OP3 afterwards. In each case, the completed review documentation was collected and examined. Through the gathering and analysis of this data it was possible to gain a better understanding of how and where tensions emerged and how the exercise of discretion in practice either helped to resolve or, at times, intensified such tensions.

Based on both observation of and interviewing care managers, all three of whom had worked for the County for several years, the core of the review process could be seen as gathering, processing and checking information from different sources and then deciding whether the placement was still meeting the older person's needs. The requirement for discretion was evident in that, although, notionally, working to a standardised procedure laid down in departmental guidelines, care managers, necessarily had to make a series of micro-decisions at each stage of the review process. Beginning with the decisions made by care managers before the review takes place, the chapter discusses each stage of the review process, highlighting the potential tensions and the opportunities for the use of discretion in each.

## **Preparing for the Review**

Depending upon the particular circumstances, care managers came to reviews with varying degrees of prior knowledge about the older person and through various channels, for example, through reading case notes, discussions with other professionals or contact with relatives. However, whatever the circumstances, care

managers had to make two important decisions at an early stage in the process. First, there was the question of *who* to involve in the review and, secondly, *how* to involve them, whether, for example, through attendance in person, or some other means such as written or verbal reports. Both of these decisions were greatly informed by the critical question of whether the older person had mental capacity. In this respect, what was known about the older person, either in case records, notes or through prior involvement, played an important part in such decisions. For example, this might reveal that, in previous reviews, relatives had been involved in cases where the older person lacked capacity.

Who was involved in the actual review was potentially critical in terms of what specific issues were raised and how, more generally, knowledge was exchanged and produced about the older person. However, decisions about involvement did not rest with the care manager alone. Before any review, a standard letter was sent to the older person informing them of the purpose of the review and that:

"You can invite a relative or friend to join us if you would like someone else to be with you." [County standard review notification letter]

It was not possible to discover, how often older people, in general, took up such invitations and in what circumstances or even whether they read or understood the letters sent to them. However, whether a relative or friend attended a review was not just the decision of the older person. According to CM3, most care managers looked at the previous assessment or review on the file, and if a family member or friend had attended before, they would make contact with them and ask if they wanted to

attend again. It appeared to be an unquestioned assumption that the older person would approve such arrangements. Special attention was paid to older people living in special dementia care or nursing settings. CM3 added 'if the person does not have the capacity to participate in the review, we would need either family, a friend or an advocate'. Therefore, it was recognised that older people lacking mental capacity always required the involvement of someone whose notional role was to represent their interests. However, the fact that a family, friend or advocate<sup>20</sup> might discharge that role quite differently (depending on various factors, including their relationship) was not raised as an issue by any of the care managers interviewed.

### **Involving the care home**

Care homes, like any other service providers, were required to complete a pre-review questionnaire providing basic information about events such as hospital visits or significant changes in the older person's circumstances in the previous year. I could not establish whether the completed questionnaire was always shared with others, including the older person, for verification. This did not appear to be the case in the reviews I observed. Beyond this, whether and how care home managers or staff became personally involved, and in what circumstances, appeared to be negotiable. One care home manager revealed that members of care home staff were not routinely involved. However, in the context of 'initial' reviews, she explained:

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<sup>20</sup> Since 2007, under the Mental Capacity Act 2005 if somebody who lacks capacity has 'nobody else who is willing and able to represent them or be consulted in the process of working out their best interests' and if a possible outcome of a review was that they would be moved, then the involvement of an Independent Mental Capacity Advocate (IMCA) from the County's approved Independent Mental Capacity Advocate Service is required. However, this study found no use of IMCAs or any other type of independent advocate in care home reviews.



CHM1: I think it's beneficial if we can, I mean the person who's going to be coming out and seeing this resident, has had no previous contact with them so, I've actually given them quite a lot of information.

I: Yeah

CHM1: Before they even come out. No I think we don't again, we don't always get involved in that routinely.

In such circumstances, where the care manager 'has had no previous contact', the care home therefore performed a critical role as provider of knowledge about the older person. Another care home manager confirmed that care home attendance was not a routine feature of statutory reviews and saw care home involvement more as a case of being invited rather than expecting to attend. They also recognised that a reviewer might want to talk to the resident in private.

CHM3: There's times if they would ask, but it wouldn't necessarily mean that in all the reviews the staff would sit in.

I: No

CHM3: They would be asked to

I: Right, OK

CHM3: It might be that they want to talk to them in private.

In cases where the older person, for one reason or another, was unable to communicate very well, another care home manager explained that:

CHM2 ...the review is never done without a member of staff being there or should be anyway

Thus it would appear that the attendance of care home staff at reviews was, to some extent, negotiable and varied according to both the circumstances and the attitudes of individual staff. However, when a member of care home staff did attend, they regarded it as an opportunity to communicate how well or not the older person was getting on and to raise any issues the care home was struggling with. For example in the case of OP3, her history of 'wandering' both inside and outside home had, initially, caused care home staff many challenges in how to manage this behaviour. Earlier reviews had apparently dealt with this issue at some length and had been used to secure additional resources for the home to help manage the problem. In the review I observed, this issue had apparently settled down. However, comments by the care home manager (CHM2) echoed the earlier difficulties:

CHM2: She likes to have a nice wander round before she goes to bed. So if you're up here you'll see her go past and then you'll see her go past the other way.

OP3: Yes, I enjoy that

CHM2: And then you get in don't you? Get in to bed.

OP3: I don't go to bed too early that way

CHM2: No you don't. You don't get into bed before you're ready to go to sleep if you do have a wander

Ostensibly, any written or verbal information provided by the home was to promote the older person's best interest. However, such information was also inevitably coloured by what was in the home's interest. In certain circumstances, care home managers approached reviews with a clear agenda of their own, for example, keeping the older person, securing resources or even having the older person moved. Therefore, the care home's involvement in a review could have significant consequences for the older person depending on what contribution was made and what outcome the care home manager was seeking. Despite this, the care managers did not always explicitly acknowledge the potential conflict of interest that followed from involving care home staff.

### **Preparing a review for an older person with mental capacity**

In the annual review observed where the older person had mental capacity (OP1), it emerged at the beginning that, whilst she had not requested that a relative or friend attend, she was expecting that a trusted and liked member of the care home staff would participate in her review.

OP1: I thought one of the carers was coming. I thought [staff member] was coming up?

CM1: Well as long as you're happy to speak to me on your own.

OP1: Oh, yes, yes

CM1: Yeah. Well, I'll go and have a chat with them afterwards. Get their perspective

OP1: She may come in yet. She may not be on duty I don't know

CM1 decided that she would seek the carer's perspective later, although it might well have been for moral support rather than her 'perspective' that OP1 wanted the carer to be in attendance. However, in the event, it appears that OP1 was 'happy' that the review would involve just her and the care manager (CM1). At the time of observation OP1 had been resident in the home for three years. Beforehand, based on reading the notes, CM1 informed me that it would be a 'straightforward' review. Given that prediction, perhaps, unsurprisingly, CM1 described it afterwards as:

CM1: A very standard, very standard review. Very uncomplicated which made a nice change and she was a very pleasant, quite coherent lady, I mean she had her moments, but I felt she could let me know if she wasn't happy or, you know, something was wrong so I thought it was quite good.

This suggested that a reviewer's preconceptions about how placement was going would inevitably have a bearing on a review's outcome. In this case, whilst CM1 worked through all the sections on the form, not only did she place her own construction on what was said, but she was also content to let potentially difficult issues go unexplored. For example, in the exchange below CM1 heard the phrase 'there's not much down there for me to do' and reflected it back to OP1 as 'you like your own company'.

CM1: Do you go and sit downstairs with the other residents at all? In the main lounge or sitting area in the garden?

OP1: Well occasionally I do. There's not much down there for me to do.

CM1: You like your own company.

CM1's approach to this review was informed by the belief that because no serious issues were recorded in the notes or raised in advance by the care home, and because OP1 'was able to advocate for herself', no one else needed to be involved. This was probably the reason why the review appeared to CM1 as 'very uncomplicated'.

### **Preparing for reviews where the older people lacked mental capacity: the involvement of relatives**

When an older person lacked capacity, decisions about who to involve and how became more important and, potentially, more complicated because who was involved in such reviews would have a significant bearing on how the best interests of the older person were represented. According to one care manager (CM3):

The majority of families, and I know, we have to be aware that sometimes families don't act on somebody's best interest, but the majority of times, a very caring family does a far better job than we ever do, of making sure that's working out OK

However, she later added:

CM3: I think the most difficult ones are the ones where the family seem to dominate the review.

Consequently, it could never be assumed that relatives would put the older person's interests over their own. The question of how best to promote the older person's interests where they lacked capacity therefore had to be decided on a case-by-case

basis, as were the equally critical questions of *whether* and *how* the older person who lacked capacity should be involved in their own review. These latter questions raised important issues, for example, of how to manage the older person's input whilst maintaining their dignity and also accommodating the feelings of others involved such as relatives.

CM2 had to decide how to manage OP2's initial care review. OP2 had advanced dementia and other serious health problems. He had been placed in the Cherry Trees about a month previously because his wife (Mrs OP2) could no longer look after him. CM2 decided to conduct the review in three parts (all of which I observed): an initial meeting at the care home with Mrs OP2 alone in order to discuss any issues that needed to be raised later with the care home; a follow up meeting involving Mrs OP2 and a senior member of the care home staff in the office; and, finally, a meeting in private with Mrs OP2 where OP2 was briefly involved. The main thrust of the meeting with the member of staff revolved around how well OP2 was settling into the home. Mrs OP2 had raised some issues whilst alone with CM2, for example, about OP2 sharing a room and not having his bed made up, which neither CM2 nor Mrs OP2 subsequently brought up when they went to the office to meet with the senior staff member. In this part of the review, Mrs OP2 appeared quite deferential or, at least disengaged, allowing both the staff member and CM2 to take the lead. As a consequence, the focus of the review shifted away from home's ability to look after OP2 and more towards his capacity to fit into the home. The effect of this shift was evident in some of Mrs OP2's behaviour. For example, she was apologetic when some of her husband's disorientated behaviour was mentioned by the member of staff. Overall, there seemed to be a lack of connection between the

issues discussed and raised in parts one and two. After the meeting in the care home office, CM2 requested that he and Mrs OP2 met with OP2 in the dining room of the care home. This venue was chosen because it was empty at the time and because OP2 shared a bed room. The third part consisted of a brief meeting which lasted just over five minutes. It was brief mainly because OP2 appeared not to grasp fully what the point of the meeting was and what was expected of him and this is discussed in more detail in Chapter Seven

In a later interview with CM2, he revealed some uncertainty about how successful his three part strategy had been. Initially, he said that he thought it went 'very well', but then became more self-critical about the third part of the review where he had tried to involve OP2.

CM2: If you remember, the third stage in that review, was seeing OP2 on his own

I: Yes

CM2: I knew I wouldn't get a lot out of him but the, the accomplishment was just to give him the respect of actually consulting him

I: Yes

CM2: Even though, he may well not say very much, and I did, if you remember, I mean I, I, it was a bit of a, I felt like I'd made a bit of a hash of it but,

I: In what way though?

CM2: Well, I kind of wanted to orientate him. Usually to set the scene, orientate the individual, OP2 and I think I rushed that bit of it.

The compartmentalised approach taken by CM2 was designed to avoid OP2 spending unnecessary time in a meeting which he would not have fully understood. CM2 criticised himself for failing to properly engage with OP2 in part three. Whilst the intention was to give him 'the respect of actually consulting him', it never really worked as a meaningful consultation exercise, if for no other reason than the fact that it came *after* the meeting with the staff member.

It was difficult to determine how the actual presence of Mrs OP2 at the review helped promote her husband's best interests any more, say, than if CM2 had spoken to her at home beforehand. She, herself, appeared quite uncomfortable throughout the various stages, but particularly during the meeting in the office when the staff member seemed to have control. From comments made directly afterwards she was glad to have seen her husband but was relieved to have got the review out of the way. Mrs OP2 declined to be interviewed formally, however a later exchange with her on the phone, suggested that she had mixed feelings about her husband going into care. With so little to go on it was difficult to disentangle fully what they were without being too speculative. However, the way in which she declined a further opportunity to talk about the review indicated both tiredness with the role of 'carer' and that she either did not want or feel able to take responsibility for 'monitoring' the placement any longer.

CM3 also reviewed a placement where the older person (OP3) had dementia and relatives were involved. It was an annual review which, according to CM3, meant that:



CM3: I started with an advantage. I had actually, dealt with this lady's assessment and arranging for her to remain in [the home] so I knew a little bit about the background and also about the circumstances of her placement.

This suggested that reviewers do not always have the 'advantage' of knowing the background of the case personally. However, in this case, CM3 knew OP3's son (Rel 1) and daughter-in-law (Rel 2) from previous involvement and already apparently established that things were going well when she arranged the review. On the day, because the care home manager (CHM2) was tied up at the beginning, the review began with CM3, OP3, Rel 1 and Rel 2 in attendance. CHM2 joined in about half way through. Although CM3 had 'felt it fairly straightforward', it transpired, when interviewed separately post-review, that neither the relatives nor the care home manager were particularly satisfied with the way the review had been structured. Both said they would have preferred to discuss the placement *without* OP3 being present. The relatives said that in the initial review, a 'two-tier' format had been adopted. That meant that OP3 was brought in for about ten minutes towards the end, more as a courtesy than as a genuine attempt at consultation, because it had already been decided that the placement was meeting her needs. In the observed annual review, OP3 was present throughout which caused Rel 1 (the son), in particular, a degree of discomfort. Rel 1 said that they would have preferred the review to have been similarly compartmentalised.

Rel 1: Well I think it should be perhaps a two-tier thing, where maybe you could have a little discussion amongst ourselves first.

I: Yeah

Rel 1: And just, so if there are any problems, maybe they're ticklish things you don't really want mum involved in, things perhaps about her hygiene or, because she was a very clean, particular person, little things that maybe come up that you wouldn't want to talk over her with, about. And then perhaps, the second part of it, with, armed with all the knowledge, all of us could go in and have a discussion with mum. Just, perhaps talk about some of the little subjects or see if she wants to talk about them

I: Yeah

Rel 1: and do it perhaps that way, which save you from doing the nasty stuff while she was actually listening to it

Both Rel 1 and Rel 2 thought there were some sensitive subjects that were best discussed without OP3 present. This was because it provoked a range of uncomfortable feelings. For example:

Rel 2: It's this awkwardness

Rel 1: Well it's, you know, almost patronising.

However, they were not just concerned with their own feelings. They were also sensitive to the fact that, on some level, OP3 was affected by what was going on around her.

Rel 1: You know, I've got memories of my mum's face – the way it's worked, right through my life and I know when she was cross with me, when she was happy with me

Rel 2: You know by a look from her

Rel 1: I know when she didn't trust me you know I knew when, and the look that I got on her face just told me that she plainly wasn't comfortable sitting there

One of the reasons that the relatives felt uncomfortable was because they could discern that OP3 was both uncomfortable in the review and cross with them for talking about her. The professionals present were, seemingly, unaware of these feelings. Rel 1 admitted, 'they're only little things, but, it doesn't make any difference to the way she's cared for at all'. Unlike the professionals, the relatives had a shared personal history with OP3 which meant that even the discussion of 'little things' at the review could provoke difficult feelings in them.

Although the care home manager was unhappy because events had meant the review starting without them, she believed it had been a good review mainly because OP3 had been involved in some way.

CHM3: What's always useful in a resident's review is the fact that everybody has some sort of participation. So, from a social worker's point of view she was able to ask 'are you happy?' 'Is everything going well?' 'Is there anything you don't like?' etc. and she was getting answers, from relatives' point of view, although they're happy with the care and everything, they've got the opportunity

I: Yeah

CHM3: And so they should always be given that opportunity, and OP3 was very much part of it. She was part of her own review.

However, Rel 1 and Rel 2 presented a different perspective on the extent to which OP3 could be said to be 'part of her own review':

Rel 1: But I think she was just as last year as she was this. There wasn't a lot of difference.

Rel 2: Well, I can remember at one point, she was sat there and she said 'who you talking about?

Both sets of comments illustrated the complexities and therefore potential tensions created for care managers in having to decide on questions of both *who* to involve and *how* to involve them in care home reviews. The three observations and subsequent interviews could not have illustrated more graphically the subjective nature of reviews with the different participants clearly experiencing the same event differently. The care manager had to find ways of managing the tensions inherent in such situations.

In the two reviews where the older person lacked capacity, care home staff were involved and had an important input on how well they thought the placement was going. In the review where the older person's wife attended she was a lot less assertive in advocating her relative's interests than in the OP3's review where her son and daughter-in-law participated. There were probably several reasons for this. Apart from individual factors such as age, health and personality, Mrs OP2 was attending her first such review, whilst for Rel 1 and Rel 2, it was their third and they would have a better idea of what to expect. Perhaps, most importantly, her relationship with the older resident was one of spouse and long-time carer. All these

factors were likely to have influenced her performance. The comparison underlines the obvious point that an older person's relatives are not interchangeable and, therefore, a decision to involve one relative as opposed to another will have a different impact.

There was no agreed procedure or general rule about how questions of involvement should be managed. To a large extent, the key questions of 'who', 'when' and 'how' were a matter of care manager discretion, although, depending on the circumstances, the care home, relatives or even the older person, could also influence who was involved. But, again, this would depend on who was informed about the review and when. When an older person had capacity they were given the choice about who they would like to be present and, as far as I could establish, there was no limit to who they could invite. They could also elect to talk to the care manager privately. However, care managers were free to examine an older person's records and talk to others outside of a private meeting. The older person could not feasibly limit who was spoken to about them. It was not possible to say how any conflicts over involvement were resolved in such cases. None were observed in this study.

Although, they might not have the final say over who was involved, care managers could exercise a greater degree of decision-making power over *the way in which* different people were involved, for example, whether the review was one whole group meeting, a series of sub-meetings or some people seen individually. However, even then, others, particularly care home staff, did not always fit in with these plans,

and on other occasions reviews need not always go to plan. Multiple stakeholder involvement in a whole group review could lead to discomfort being experienced by some if not all participants. A compartmentalised approach, on the other hand, could lead to issues falling through the gaps.

In situations where the older person lacked capacity, care managers faced a more complicated set of decisions. The presence of relatives' perspectives, where available, could prove helpful in establishing a better idea of whether the older person's needs were being met, however, the presence of relatives alone did not always mean that the older person's best interests were protected. Care home managers and staff varied in the extent to which they wanted to be present at the review. When they attended, it was seen an opportunity to provide information to the care manager about how the older person was getting on. Whilst the care home's interests and those of the older person might overlap, this was not necessarily the case. Therefore, in setting up the review the care manager had a series of potentially difficult decisions. In attempting to resolve tensions in one area, it could create tensions elsewhere, for example, too strong a complaint about needs not being met might lead to a care home wanting additional resources or asking for the older person to leave. In any event, the outcome of this preparatory process inevitably had a significant bearing on the knowledge produced about the older person and what, if anything, should be done with it.

This highlights that an important amount of knowledge about older people was produced in various departmental documents and that the way the different

documents were used varied, again, often apparently down to the discretion of practitioners. Care managers also vary in how much they know about the older person before the review. In the case of annual reviews or initial reviews following an admission to a care home from hospital, the likelihood is that the care manager will have little or no prior knowledge, except that gathered from case records.

### **The use of pre-review questionnaires**

All service users supported by public funds in the County had case information stored about them in both electronic and written case records. However, this information could often be quite basic, incomplete and not fully up to date. For example, the care home managers highlighted that often records were not sent from the hospital team to the locality team which had an impact on initial reviews following a hospital discharge. The interview with the senior social worker also highlighted the poor quality of much of the information recorded in case files generally. This meant that care homes played an important role in providing more up-to-date information about older people for reviews.

As outlined earlier, a pre-review questionnaire (See Appendix 5) sent to care homes prior to the review asked them to comment on whether the older person had experienced any major change events. Questions, such as the one below, therefore provided an opportunity for the care home to shape both the review agenda and how the older person was 'constructed', even if a member of care home staff did not attend in person.

How have the Client's needs or circumstances changed since the last review?

(Adult Review: Residential Care Provider Information Sheet)

There was considerable potential for discretion to be used in how these questions were interpreted, which meant that the quality and relevance of responses was variable. For example, from examination of the questionnaire completed in respect of OP1, in response to the question:

'What is the communication/contact like between staff and the Client's family and friends?'

The care home response was:

OP1 is well liked and staff are able to talk to her family well.

This shed little light on the quality of the relationship between the home and any friends or family of OP1. Also, as with others examined, the form was left unsigned. However, while there were obvious problems with the quality of information recorded on pre-review documentation, it was claimed by one care home manager that, sometimes, the documentation was not received at all.

CHM1: Normally, we would get, probably written confirmation that they are coming to do the review and we do get a short questionnaire which they ask us to fill in prior to the visit. But then, on the other hand, we have had, for instance, someone rang up and said is it alright if I come along in half an hour?

I: This was an annual review was it?



CHM1: Yes and just turned up like that, so there was no sort of pre-questionnaire or anything.

Another care home manager confirmed the variable and *ad hoc* nature of practice around the pre-review questionnaire.

CHM2: We get this [the questionnaire], we sometimes, we don't always, we sometimes get paperwork prior to the review a week or two weeks before, saying will you fill it in?

I: You don't always necessarily get that?

CHM2: No, sometimes it arrives on the day that we get the review. So, therefore you don't have to, to fill that paperwork in. They *might* want it.

The stress in the phrase 'they might want it' indicated that, even when completed, the questionnaire was not always asked for by the care manager, which was another area where care manager discretion was evident.

From a care manager's perspective, according to CM3, she did not usually get the questionnaires back but that even when she did, they contained 'very scanty information'. However, she added that when the forms were received, it saved time if she could 'do some reading prior to the visit', which tended to underline the importance of records in how an older person's situation was understood.

That said, there was no evidence of care managers taking note of any such prior information in the reviews observed. In the case of OP2 this was probably to do with the fact that the care manager (CM2) was already involved and it was a very recent move into the home. However, with OP1 and OP3, they were annual reviews where neither care manager had been recently involved. Therefore, whilst the pre-review questionnaire could provide the opportunity for the care home staff to inform the review agenda by highlighting key issues, it did not always fulfil that role. As with much else in the statutory care home review system, practice was contingent, *ad hoc* and variable.

### **Checking the Care Plan(s)**

The other main source of written information about the older person was the care plan. Although, what exactly constituted the care plan was also open to interpretation. The older person would have had a care plan drawn up by a care manager following their initial assessment. As the CQC inspector made clear, the care plan was *the* key document in the whole process as it was on the basis of the care plan that the care home was providing the service to the older person. As the senior manager, the DPM, stressed, the care plan formed the basis for the 'outcomes' that the service user wanted to 'achieve'. A copy of the local authority care plan would be stored in the care home's records for that resident. However, care home managers explained that care homes drew up their own internal care plan once someone was admitted. This was more of a dynamic 'working' document which the care home would work from on a day-to-day basis and update regularly as prescribed by care home regulations. However, on closer examination, there was a lack of common agreement amongst different stakeholders about exactly *which* care

plan was actually being reviewed. That fact that different care plans existed led me to frame the following question to different stakeholders:

I: When a social worker says that they check the 'care plan' - I'm not always sure whether they mean the original care plan that was produced by the social worker when the older person was admitted or the one that the home works to and updates regularly from its own reviews - or are they one and the same? So, basically, if at a review, the social worker asks to see the care plan - what do they end up looking at?

From a care home manager's perspective, CHM1 replied:

The social worker would look at our up-to-date care plan, one of our own staff would probably be a part of the visit or would at least provide information as required.

The care manager, CM2, replied at length:

This is not an easy question to answer. They are definitely not one and the same. The home's care plan should reflect issues of specific management of an individual, issues around weight, diet, continence, health, choice over diet and personal care and these can change depending on the individual. The "support plan" which is what we do<sup>21</sup> now, deals with generalised issues which is about the appropriateness of the placement, so it's about outcomes, safety, all those government targets raised in *Putting People First* policy. We do ask to see the person's care plan, written by the home, at review just to check they have one and it is up to date and that it is consistent with the stated outcomes in the support plan and appropriate, in other words meeting needs and outcomes. I think you have stumbled on a problem as to how one influences the other

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<sup>21</sup> With the implementation of the personalisation agenda came a change in terminology. Practitioners were required to complete 'support plans' with service users rather than 'care' plans.

and it is a source of confusion in practice. The home's care plan is usually not reviewed, it is a review of the support plan. So to answer your question, when a social worker says I'll check the care plan (support plan) they must be referring to the one originally produced by the social worker. Would be interested in what others think.

The senior social worker, (SSW), replied:

Well the answer!! Is there one?? I think we all make up what suits. However my understanding is when the person enters a care home we provide an assessment/care plan. The home will should take this on board but homes usually produce their own care plan. This is what we would look at review - basically to see records are being kept up to date etc. Ask someone else and you will probably get a different answer - you know how it is.

It was therefore evident that there was a considerable degree of confusion about how written records should be used. What happened in reviews in terms of *which* records were actually checked and *how* they were checked, appeared to be quite arbitrary and varied according to the individual care manager. Whilst CM1 favoured looking at the care plan (the care home version), according to CM3, her approach was that:

CM3: I would normally try to do that, look at the care plans and everything before I start the review so that, sometimes you'll just pick up a little clue from there, that's there's something and you need to think well perhaps I need to bring that out either within the review or with the family or with the manager of the home.

In the review observed, CM3 actually inspected the care plan (the care home's version) *after* the review but, in any event, whenever it was checked (before or after the review), the care plan held in the home provided important up-to-date information about the older person which was necessary for the review. Apart from any notes written daily by the care staff, the care plan should include Medication Administration Records (MAR), weight and Waterlow charts (pressure sores). However, such records needed to be interpreted to make proper sense of them and some doubt emerged about whether care managers were always equipped to know what to look for and how to interpret them.

CM1: But I do worry when I sit here with very experienced colleagues and colleagues who have been in the job a very long time, and they say to me I would never have looked for that in a review

I: Uhm

CM1: Never looked at that in the care plan, I didn't realise and I think there need to be a better structure for review.

Talking about a recent review CM2 confessed:

CM2: I was checking the notes today, you know, checking the care plan,

I: Yeah

CM2: Checking that, those, those records you know, I mean I had no idea what I was looking at really.

Therefore, levels of both confidence and competence varied amongst practitioners not only in understanding the status of the care home records but also how to interpret them. CM2 was probably not the only care manager to have been in that situation, which suggests that, sometimes, discretion was exercised from a position of knowledge and sometimes from a position of ignorance. This actually suggested another area for the exercise of discretion: practitioners deciding about how much knowledge they needed in order to perform their role satisfactorily. CM2 appeared to think that although 'he had no idea what he was looking at', this did not trigger a training need. However, CM1 did explicitly flag up the need for proper training for reviews.

CM1: I think there should be guidelines and guidance on training for review, not something you just go out and look around and chat to someone.

When I sought clarification it appeared that there was no specific training available in the County. Once again, this highlighted the *ad hoc* manner in which much of the system operated.

I: Is there any, is there currently any specific training for people doing reviews?

CM1: As far as I'm aware, it's a case of whichever team you walk into, whoever's been doing them, has been doing them, or a line manager or supervisor will tell what you need to do.

I: Right

CM1: It's very, very, *ad hoc*

The inspection of care home records should normally complement the face-to-face part of the review in order that the care manager was able to determine, in as full a way as possible, whether the older person's needs were being met by the care home. However, it emerged that the practices around this part of the review preparation were, as with other key parts of the process discussed in this section, such the use of pre-review questionnaires and deciding about whom to involve, could be erratic in how they were carried out. The variability in practice suggested that the actual face-to-face part of the review involving the older person and other stakeholders took on a lot more significance in terms of how information was gathered and the decisions made.

### **During the review**

In the observed reviews, care managers worked through the standard review format in their own way, for example, by paraphrasing questions or running questions together. Their preparedness to explore specific issues in depth varied considerably, as did the extent to which their recording captured the discussion. Reviews were conducted differently depending on the mental capacity of the older person involved.

### **Conducting a review where the older person had mental capacity**

In the 'uncomplicated' review which involved just CM1 and OP1, a cheerfully brisk tone was set from the start:

CM1: Hopefully everything is as it is. We'll just leave things as they are, but we'll see how we go...

The care manager kept reasonably closely to the review form in terms of the sequence in which they asked the questions (see Appendix 5). However, *the way in which* the questions were paraphrased and delivered helped construct responses that were unproblematic which was, in turn, reflected in the way in which the record was written up. Detail was minimal and any comments were almost always positive. For example, under the heading 'Quality Issues', the first question on the form asked:

Do the staff provide the help in a way that the client is happy with? Are there any issues or problems?

CM1 expressed this as:

CM1: OK. So you get on well with the staff here?

OP1: Oh yes, get on with them well

CM1: Yes

OP1: They're nice

CM1: Good

OP1 They couldn't be nicer really. I wonder how they've got all the patience that they've got ...*Laughter*

CM1: You find them helpful?

OP1: Oh yes

CM1: If you feel you're not happy about something you can, you can talk to them or...



Apart from the obvious leading nature of her questions, CM1 disregards the prompt on the form to enquire whether 'there were any issues or problems'. In the subsequent review report, the above exchange was simply recorded as:

(OP1) said that the staff are very nice and helpful. She can talk to them about anything. They are very patient.

CM1's 'economical' and light-hearted approach, in many ways, appeared to suit OP1 who, when interviewed, described the review as 'very fair and to the point'. However, having been given the opportunity, OP1 did raise certain topics that appeared to concern her and which could have been explored in more depth. In the event, CM1 chose neither to pursue nor to record them. For example, Question 4 'Can the client choose what time to get up in the morning, go to bed at night and where to spend the day?' led to the following exchange:

CM1: You sleep well then?

OP1: Yeah

CM1: Good appetite?

OP1: I sleep all day as well     *Laughter*

CM1: Well, I think you're allowed aren't you? Let's be honest

OP1's remark 'I sleep all day as well' was apparently taken as a joke and was met with a light-hearted response by CM1. However, taken at face value, the fact of sleeping all day could be down to various reasons, including boredom, depression, illness or over-medication and, perhaps, required further exploration. Arguably, in a jokey, light-hearted context, every comment made should not be taken at face value.

This illustrated how the brisk/light-hearted tone adopted by CM1 in this instance coloured the discussion to the point of making it difficult to 'change gear' and explore difficult issues. OP1 brought up two specific issues of apparent concern. However, CM1 either did not pick this up or chose to leave them unexplored and unrecorded. The first issue was when OP1 brought up the subject of her sister who also lived in the home. The sister had advanced dementia and frequently sought OP1's company. It had apparently been decided that it would be a good idea for her to move rooms, closer to OP1.

OP1: So they moved her to the room just opposite

CM1: Oh, that's nice. You can look in on her ...and she can look in on you

OP1: She more or less looks in on me

CM1: Right

OP1: I don't often go over there but she comes in here most of the time. Not every day.

CM1: No

OP1: She don't like her company – that's the trouble

CM1: Ah, bless. There's a lot of people like that though isn't there?

CM1 seemed not to appreciate the importance of the issue to OP1 and, unfortunately, appeared rather patronising and dismissive ('ah bless'). However, later in the review, the discussion again returned to the sister:

OP1: Well, I've got me sister here and she's a bit of a ...headache, but there

CM1: Hmm....You can't have it all you know, heh, heh, heh

OP1: Well, she's got, she's got this Alzheimer's since she's been here. And she makes my life very hard sometimes

CM1: Hmm

OP1: But there

CM1 It's a very, very difficult ..

OP1's use of the phrase 'she's a bit of a headache', indicated that her sister was clearly causing her some difficulty at The Oaks, however, it was not mentioned in CM1's report. The comment 'You can't have it all you know', CM1 seem to suggest to OP1 that she should resign herself to the situation. CM1 was keen to move the review on as quickly as possible.

The other instance where OP1 brought up an issue of her own was in response to the question:

Is the client satisfied with the equipment and facilities available at the Home?

This exchange led to a disclosure from OP1 about a sensitive incident involving a male carer.

CM1: Right. Are you happy with your room?

OP1: Yes, very.

CM1: Yep

OP1: Yes, it's always kept nice and clean and bed's changed every week. We have a bath every week...somebody to do it for us... so we don't go about dirty... no, there's nothing you can complain about at all. The only thing was, the other week, I was going to

have a bath and one of the...men, he comes from one of them...Zimbabwe or somewhere like that

CM1: Oh, one of the carers

OP1: He says I'm going to bath you tonight. I said 'oh yeah?' I said I'm not having a bath then. He said 'why?'. I said because I don't want one

CM1: It's your choice...absolutely

OP1: I said either [female carer] baths me or I go without. Or I do it myself.

CM1: Right

OP1: I think he was only pulling a leg I think. Think he was just trying it on to see if I...

CM1: He knew you'd react.

OP1: What I felt about it...

*Pause whilst CM 1 writes some notes*

CM1: What about the rest of the home? The grounds and the actual building downstairs, all the rooms – are you happy with all that?

Again, CM1 managed the situation by deflecting OP1 with another question. The, not insignificant, issue of whether a female resident should be given a choice of having a male carer to assist her with bathing was left unexplored. In the report, CM1 recorded:

[OP1] said yes, the home is always kept nice and clean. Her bed is changed every week.

[OP1] said they have a nice garden and sitting room.

No mention was made of the concern about the male carer at bath time, neither was it brought up with the care home manager. About the incident CM1 said afterwards:

I: During the review, she [OP1], raised the point of a carer, a male carer, coming to bath her. What did you make of that? I mean did you think she wanted you to take it up or, what were your views when she mentioned that particular.....

CM1: ....no, because the way she was telling me in retrospect was that she dealt with it basically. She'd said 'no', end of story. She was able to advocate for herself. She can say 'no' or, she's not happy.

In CM1's account they took no further action because OP1 was able to 'advocate for herself'. Whilst this may have been true, and OP1 did not explicitly ask for anything to be done, nevertheless, CM1 appeared to show no curiosity as to why OP1 had brought the subject up in the first place. This suggests that whether issues raised by residents are taken up and passed on – even when the older person has capacity - appears to be largely down to the discretion of the individual care manager and the importance they place on anything raised.

The review process was therefore tightly controlled by CM1 and OP1 seemed content mainly to go along with that approach. When I subsequently asked OP1 what she understood the review was for, it was clear that she had grasped its, predominantly, bureaucratic function: 'you must have certain rules and regulations..... to run a place like this'. This understanding was probably influenced by CM1's largely bureaucratic approach. With CM1 working briskly through the structured set of questions, OP1 was left little space to introduce her own issues and when she did, there was no real engagement with them by CM1. The review record, which was sent to OP1, contained the minimum of detail and concluded:

OP1 presents as very settled and happy at The Oaks. Level of care appropriate at time of review. Recommend placement to continue.

OP1 had duly signed and returned it, thus completing the bureaucratic ritual for that year. OP1 had not requested the review but, nevertheless, had responded to CM1's questions and revealed something of herself in the process. As she said afterwards "what I told was the truth so it's up to them what they do after that". As it turned out, nothing was done with any of it, which OP1 appeared to realise afterwards, if not at the time.

Overall, care manager discretion was evident at every stage in this review. The care manager set the tone by choosing how the questions were phrased and delivered, if at all. She also managed the discussion to reflect her own priorities and wrote the review record in ways which reflected her view of what was important. The fact that OP1 had capacity was a key factor in limiting the review to two participants.

Arguably, in such circumstances, this maximised the degree of control that CM1 was able to exercise over the way the review was conducted and subsequently recorded. In this particular review, CM1 appeared to be content for it to be a tick box exercise and this was the way it turned out, a point OP1 appeared to acknowledge afterwards.

Reviews where the older person lacked capacity required the involvement of others such as relatives and care home staff. In such circumstances, the degree to which

care manager autonomy was exercised and the agenda shaped was more complicated. Their control was significantly constrained by others and varied according to the specific circumstances.

### **Conducting reviews where the older people lacked capacity: managing the involvement of care home staff and relatives**

In CM2's compartmentalised approach to OP2's review, the first part involved CM2 going through the form with Mrs OP2. CM2 was noticeably more idiosyncratic (in the sense that the structure did not follow the topics laid out in the review form) than either CM1 or CM3 in his interpretation of the questions on the review form. This might have been his normal style but it was probably also a consequence of it being an initial review where CM2 had already been closely involved with OP2 and his wife. Having said that, Mrs OP2 was clearly anxious about certain care issues, yet, as with CM1, CM2 evidently did not necessarily share her concerns to the same degree and managed the discussion accordingly. As with CM1, the way in which questions were framed helped set the tone of the review. For example, after two minutes of discussion between himself and Mrs OP2, CM2 asked:

CM2: Right, OK. Well, is there anything else you'd like to raise with me in private, you know, I mean, 'cos I get the idea you're fairly contented

To which Mrs OP2 replied:

Mrs OP2: I'm fairly contented, but what I can't understand is, whenever I come in his bed's never made up.

CM2: Yeah

Mrs OP2: I wonder why? It's made up today

CM2: It is, that's 'cos we're here.

Mrs OP2: Yeah

CM2: Yeah

Mrs OP2: I don't know why they don't make it:

CM2: No I don't know

Mrs OP2: Maybe it's, I don't think it's wet, because he's tied up (*wearing an incontinence pad*)

CM2: Yeah

Mrs OP2: I don't know why

CM2: Is it crucial?

Mrs OP2: Not really.

CM2: Not really, no.

Mrs OP2: I just want to make sure they wouldn't dare leave him where he is (*out of bed*) all night would they?

It was evident that Mrs OP2 was worried that her husband was neglected at night and that his bed was never made up. However, CM2 did not seem to regard that as important and the question 'Is it crucial?' effectively discouraged Mrs OP2 from pursuing it any further. In any event, no record of this concern was made. Having



steered Mrs OP2 away from her concern, CM2 then immediately brought up one of his own.

CM2: Yeah, can I, can I ask, you know that time when we saw him together, a few weeks ago<sup>22</sup>?

Mrs OP2: Yes

CM2: And we thought he was a little bit dishevelled

Mrs OP2: Yes

CM2: I mean, since then you know

Mrs OP2: He hasn't been

CM2: He hasn't been.

Mrs OP2: He was that day wasn't he?

CM2: Yeah, no, he was only wearing one sock

Despite the fact that OP2's dishevelment was a concern of CM2, this was also not recorded on the form. Not every issue raised by Mrs OP2 was deflected or downplayed by CM2 and the most obvious issue where CM2 shared Mrs OP2's concern, related to the psoriasis on OP2's buttocks, which CM2 wanted to link to his own particular worry about the risk of OP2 developing pressure sores.

Mrs OP2: 'cos you see he has got a bad bottom

CM2: Well I'm worried about pressure sores that's, that's the issue.

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<sup>22</sup> Referring to when OP2 was first admitted to the home.

Mrs OP2: I'm wondering about those. You see I can't really say I can't really say 'please may I see his bottom?' can I?

CM2: No

Mrs OP2: I've wondered if he has

CM2: Yeah. No, I've meant, I've put, I've made a note of the psoriasis, he's got psoriasis has he?

Mrs OP2: Yes he has, you see it's all on his bottom where he sits and it needs treatment

These extracts illustrate the way in which CM2 managed Mrs OP2's contribution, at times downplaying her concerns, at times endorsing her concerns when they resonated with one of his and, at other times, introducing his own issues. During their conversation together CM2 and Mrs OP2 touched on a range of issues, including: OP2's mobility; his psoriasis, the fact that he had a shared room, his eating habits and his preferred bedtime. However, under the heading 'Family View' on the form, Mrs OP2's comments were summarised very briefly.

Mrs OP2 is satisfied with the home and the care he receives.

The issues raised by Mrs OP2 suggested something less than full satisfaction. Therefore, this simple phrase did not fully reflect the full extent of concerns covered. Amongst other concerns, it raised the question of how the care manager at the next review – possibly a year on - would have any sense of what issues OP2 faced on admission to the home.

The first part of the review involved just two participants and, again, it was clear that the care manager was able to conduct and subsequently record the review in ways which largely reflected his priorities. However, the second part of the review, which involved a senior member of staff, illustrated a more complex negotiation over how priorities were established in a context of changed group dynamics. The staff member became the focus. This was helped by the fact that he was sitting in his office, at his desk and with OP2's notes in front of him. In the absence of any specific set questions from CM2, the staff member took the review as an opportunity to talk about how well he thought OP2 was settling into the home and, as such, it felt as if it was almost a 'probationary' period for OP2 rather than the other way round. This was reflected in the report, where CM2 recorded that:

Staff member said that OP2 presents no problem. There is no challenging behaviour.

As mentioned earlier, throughout this part, Mrs OP2 said very little and largely deferred to both CM2 and the senior staff member (both men) over what issues were discussed. CM2 was unable to exercise the same degree of control over this meeting as he had in the previous one. However, CM2 did raise the subject of the skin problems on OP2's bottom. Raising the issue led to the staff member producing a set of photographs taken of OP2, practically naked, at the time of admission. This was intended to reassure the meeting that, since his admission, there had been no deterioration in the skin problems. I found it difficult to look at Mrs OP2 at that point. However, she made little verbal reaction and it appeared that she did not really know what to say in the circumstances. It was a shocking revelation because it looked like

a clear breach of dignity. In the subsequent interview CM2 agreed it was both a breach of OP2's dignity and 'choice' and it turned out that was not the first time he had encountered such a practice in a care home:

CM2: Yeah, that's the second time I've seen it because I think, I think whenever you mention a pressure sore to like a nursing home, you know, they, they, I, learnt only the other year, when I did that [different county] case, the [different case] case

I: Yes

CM2: You know, I mentioned pressure sores and immediately the photos came out

I: Oh, really

CM2: Because I think it's to do with some kind of accountability, they probably feel that, you know, they have to, they have to make sure that they're covered in some way that they're not responsible for.

CM2's interpretation that the taking of such photographs was a defensive practice on behalf of care homes was probably correct<sup>23</sup>. CM2 was genuinely shocked by the episode yet, the only record of this part of the review came under the heading 'Provider View', where CM2 referred to the 'photographic evidence' in a way which was accepting rather than critical of the practice, contrary to the view expressed in the interview.

#### Provider View

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<sup>23</sup> I asked the local CQC about this and they confirmed that they were aware that such practices took place. Apparently care homes and hospitals took such photographs to help defend against charges of negligence.

(Staff member) from the [Home] said that while there has been a deterioration of OP2's mobility on the other hand his skin integrity has improved. He came in with pressure area sores that have now healed. There does not appear to be so much evidence of his sorosis [sic]. There is photographic evidence to support this [OP2 review record].

OP2's review highlighted how the participation of care home staff could change the review dynamics and hence the agenda that was followed. It also appeared as if it could influence how the event was subsequently recorded.

In the first part Mrs OP2 had raised specific concerns when alone with the care manager. However, these concerns were not always carried through to the meeting with the staff member, neither were they always recorded. Even when they were, they were not converted into action points. For example, in the report, CM2 recorded that 'Mrs OP2 said that she has not seen him walk since being in the home', yet, not only was this point not raised in the three-way meeting, it was also not flagged as an action point in the report.

In the three-way meeting in the office, Mrs OP2 was outnumbered by the professionals. She was quiet and played no obvious part in shaping the agenda, which was strongly influenced, if not exactly controlled, by what the member of staff wanted to say. CM2 made some representations on OP2's behalf, but nothing subsequently emerged as an action point for the home. The only action point recorded was aimed at Mrs OP2 to assist in the 'personalisation of OP2's living

space'. Overall, it appeared that, despite various concerns expressed by both the relative and the care manager beforehand, when the staff member participated, his agenda dominated this review. It is difficult to say why this was exactly. The fact that he was male might have been a factor. However, perhaps more specifically, it was the staff member's own territory and he seemed to derive some authority from this - whilst Mrs OP2 and even CM2 came to adopt more deferential positions for the same reasons. That the care home's agenda took precedence reflected, to some extent, the power of both the location and the institution in disabling the influence of people from outside. However, it also appeared to have been a reflection of CM2's use of discretion and either his apparent lack of appetite for investing time and effort in the role of advocate on this occasion or his lack of confidence in challenging care home practices.

The OP3 review also involved relatives and the care home, however, on that occasion it was in the context of an annual review rather than an initial review meaning it had less of a 'probationary' feel to it. However, the group dynamics were different for other reasons as well. Not only did it take place in OP3's bedroom (her territory), but there were two relatives involved who were both more assertive than Mrs OP2. The care home manager (CHM2) arriving late also meant that the process was already underway allowing the care manager and relatives to agree the agenda.

The participation of both the care home manager and relatives, together with the fact that this was a 'whole group' review, presented a complex challenge to CM3 in terms of the interrelated tasks of managing the agenda, managing the people involved and

managing the information gathering process. In addition, the review took place in a single, furnished bedroom with limited space<sup>24</sup> and insufficient chairs for everyone to sit on. CM3 began the review by addressing OP3 directly:

CM3: I was explaining that you came to the, here, a few years ago now but I came to see you last year to see how you were getting on, and we sorted out a little bit of what we needed to sort out and then every year, I come to see you and talk to you and your family, we call it a review

OP3: Yes

CM3: Just to see how you're getting on

OP3: Yes

CM3: To see if being here is still working well for you. And it's a chance for your family to say how they think things are going

OP3: Yes.

'Yes' was a recurrent response from OP3 throughout the review and illustrated a critical challenge facing CM3. She wanted to direct her questions to OP3; however, she was aware that the relatives and the care home manager were actually going to be the information providers. Consequently, after only three minutes, CM 3 asked:

CM3: Perhaps I could ask your son and your daughter in law how things have been going a little bit? They, perhaps, can give me some information?

OP3: Yes

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<sup>24</sup> The room measured approximately 4.5 X 3.5m. and contained a single bed, bedside table, a chest of drawers, dressing table and wardrobe. There were two chairs already in the room and additional chairs needed to be brought in. I sat on the bed.

Rel 2: OP3's settled well, haven't you dear? She's settled well. It took a little while.

The varying forms of address in Rel 2's latter comment ('OP3', 'you', and 'she') illustrated both the complexities and practicalities of talking *to* someone and *about* them at the same time. The task was further complicated by the home manager, CHM3, arriving late and having to be put in the picture, the effect of which was to situate OP3 even more as the object of the discussion rather than a participant in her own review. For example:

CM3: I was asking about the food and [OP3] said it's very nice but I was asking if you got a choice at meals and she was saying she didn't think there was

CHM3: Yeah, no they do. They get a choice of...the trouble is with people like OP3, it's a bit unfortunate because they do the menu on a Sunday....

Rel 2:... can't remember..

CHM3: So, she can't remember by Wednesday, Thursday what she's ordered

Rel 2: Right. So, they order in advance

CHM3: Yes, but you see normally here, that would be fine

Rel 2: She wouldn't order anything she didn't like anyway

CHM3: But OP3 wouldn't remember you see, would she?

This extract illustrated the complexities that could arise from multiple involvements in reviews, particularly where the older person lacked capacity. It also illustrated how such reviews were a potential area of contest amongst those involved over what



exactly was in the older person's interests. In the process, it could become an emotionally uncomfortable experience for some parties involved. All of these dimensions presented a complex challenge for the care manager in ensuring that the review remained focused on meeting the older person's needs but in doing so maintaining a degree of independence in respect of the decision-making about the older person when surrounded by others who could claim to know the older person a lot better.

### **Post Review: Recording and implementing action points**

Arguably, the emotional discomfort of participants was justified if it meant good outcomes for the older person. In OP3's review, CM3 believed that the review had enabled OP3 to voice two real 'quality of life' concerns. She subsequently recorded the following "Actions to be Taken" in the report.

1. [Home] to arrange for a copy of her weekly menu to be given to OP3
2. To arrange for OP3 to have a bath daily. Although OP3 would prefer it to be in the morning she and her family are aware this may not always be possible.

However, from the subsequent interviews, it transpired that neither the relatives nor the care home manager thought the action points were workable because other similar strategies had been tried before and had not worked. This appeared to be mainly due to OP3's very poor memory. However, the lack of an available 'carer' to implement the task of reminding also seemed to be a factor. For example:

CHM3: ...unless a carer is able to go and find the piece of paper and say this is your, this is your menu for this week it's not going to be effective is it?

I: No

CHM3: We did think about a board, on her wall, you know, how about we write down what you've ordered. That might be a way round it. So, but yes, we haven't yet implemented anything yet.

Even though from experience they knew the actions were unworkable, neither the relatives nor the care home manager challenged CM3's recording of the action points. The two main reasons for this were, first, to have challenged at the time of the review risked upsetting OP3's feelings and, secondly, they appeared to know, from experience, that the 'action points' would not be followed up and that they would be trusted to carry them out. This provided the relatives and the care home manager the opportunity to use their discretion to quietly ignore them and this turned out to be the case. CM3, like the other care managers, did not follow up her report and, therefore, whether the action points were actually 'actioned' was left to the discretion of the care home staff to deal with in their own way and, in this case, with the tacit agreement of the relatives. In the meantime, CM3 seemed to believe genuinely that the review had made a positive impact in these areas.

This episode illustrated how the exercise of discretion in reviews with multiple involvements was seldom just the preserve of the care manager. It also underlined, more generally, the uncertain status and uses of review reports, the completion of which seemed more like a bureaucratic ritual than the creation of a working document owned by the parties involved. According to the locality team manager 'only a minority' of people – mainly relatives – challenged reports for accuracy.

The review report varied in each review observed in how far it fully captured the discussion. What was eventually recorded as a priority for action also varied significantly from one review to another, from almost pre-determined (OP1), to minimal and arbitrary (OP2) to the review of OP3 where the action points were notionally responsive to comments made by the older person but were unlikely to actually happen.

## **Conclusion**

Despite the existence of checklists and operational guidelines in the County, on close examination, review practices varied significantly. This depended on a range of factors, for example: the circumstances of the review; the capacity of the older person, who was involved, their relationship to the older person and what their particular agenda was. From the examination of three different reviews, it appeared that much, but not all, of how the review system was implemented fell within the discretion of the individual care manager and here, it appeared that 'quality' (in the sense of really engaging with the older person and those around them and exploring relevant issues and following them through) was compromised by the, apparently pragmatic, desire to complete the piece of work as speedily as possible.

The greatest potential opportunity for the exercise of care manager discretion appeared to be in the review where the older person (OP1) had capacity and where no other party was involved. In this review, the older person had suggested she was expecting a trusted carer from the home to attend but the care manager did not

follow this up. In the event, various issues were raised but were neither explored nor recorded.

In the reviews where the older people lacked mental capacity (OP2 and OP3) necessitating the involvement of others, both the process and outcome of the review was more likely to be negotiable amongst the different parties, particularly where the others had more claim to knowledge about the older person. However, the care manager had control, seldom challenged, over the review report. These contained sketchy details and action points that were inconsistent with what had been discussed.

In addition to the care manager, other key participants in the review process, such as care home staff, relatives and residents themselves could, and also did, use their discretion in ways that shaped both the process and outcomes of the reviews. In the reviews I observed, the people who contributed least to decision making in all stages of the review process were the review subjects – the three older people. However, their relative passivity could not simply be explained by a lack of capacity or a lack of engagement. In Chapter Seven I focus on the role they played in the reviews and examine the meanings that they attached to the experience and how they, too, exercised discretion over the extent to which they participated in the process.

## Chapter Seven: Whither the older person?

### Introduction

The previous chapter illustrated how the older people were both talked about and talked over and, albeit often minimally, constructed in simplistic ways in review paperwork. In particular, the older people who lacked capacity became a site of contested knowledge, as others around them made judgements about their ability to participate and in what ways, how they were getting on, what was in their best interests and what should happen to their placement.

In Chapter Four it was explained that a specific research objective concerned examining the role of the older person in their own review and discovering the meanings they attached to the process. However, because they lacked mental capacity it was only possible to interview one of the three older people whose reviews I observed (OP1). I therefore decided to supplement this data by interviewing older care home residents who had been involved in a review. (See Appendix 2 for the topic guide which formed the basis of the interviews with older people). However, gaining direct access to older care home residents proved much harder than anticipated for a variety of reasons which will be critically discussed in Chapter Nine. In the event, it was possible to interview two further older people. These were a woman (OP4) who had been admitted to The Sycamores (a privately owned care home with nursing) six months previously and had participated in her 'initial' review and a another woman (OP5) who had been a resident at The Oaks for

six years and whose most recent annual review had taken place two days before my interview with her.

This chapter first discusses the findings in respect of the three older people who had mental capacity. It then examines the findings in relation to those who lacked capacity. The two sets of findings are compared. The conclusion suggests that the tensions associated with the review system were more easily resolved when the older person either voluntarily adopted or was placed in a role of passive participation.

### **'I've got no complaints': the cautious and passive participation of older people with capacity**

OP1 had mental capacity and her annual review consisted of just her and the reviewer (CM1). As discussed in the previous chapter, CM1's approach probably played a part in shaping the way in which OP1 subsequently responded:

OP1: I haven't got any grumbles at all really

CM1: That's what I like to hear. Makes my job a lot easier

OP1: Yeah, I thought it would

CM1: I like happy customers

Whilst CM1 framed the review from her perspective, OP1's response suggested that she was far from naïve about her role ('I thought it would'). Her 'knowingness' also

came through in the way she jokingly asked CM1, at one point, 'Are you writing all this down?'. OP1 therefore understood that the review was predominantly a bureaucratic requirement and was prepared to treat it as such. When interviewed afterwards OP1, again with humour, highlighted how such bureaucratic encounters had an almost 'game-playing' dimension to them.

I: I suppose it will be another 12 months now?

OP1: Yes it says 12 months

I: Yeah

OP1: Yeah

I: And, you know, it will be the same thing again.

OP1: Yeah. I'll say 'ditto' - laughter

Therefore, OP1 was not simply a malleable subject. She had not requested the review. However, she was prepared to go along with a format which required her to largely play the role of a passive answerer of questions, mainly because, on one level, it met her needs as much as those of CM1. Therefore, most of the review consisted of OP1 responding in a fairly routine fashion to CM1's questions. Nevertheless, whilst OP1 mainly treated it as a bureaucratic exercise, the effect of actually being asked to reflect on her life in the home led to her raising, what appeared to be, two genuine concerns. One concern was about her sister who had dementia and lived in the same home and whom had been moved to a room closer to her own. The second concern involved an experience with a male carer at bath time. However, as explained in the previous chapter, deeming the review

'straightforward', CM1 appeared to be keen to get through the form as quickly as possible and was disinclined to dwell too long on any one issue. This manifestly 'people-processing' approach was probably a contributory factor in OP1's dismissive comments about the review when interviewed later.

I: Is there any real value to you in having that meeting?

OP1: Not really

I: No

OP1: Well, if I have any grievances I tell them [the care staff]

I: Yes

OP1: They put it, if they didn't put it right I should go to the management and ask them why.

Another reason why OP1 appeared to be dismissive of the review was that if it was supposed to be an opportunity to air any grievances about the home then she asserted that she was already capable of doing that herself directly. Although, whether 'putting things right' was always as straightforward as OP1 indicated, was doubtful given what she had said in the review itself:

OP1: Oh yes, some of the things, you don't always think they're as good as they could be, but if it isn't you just mention it at the meeting and something's done about it.

CM1: Good

OP1: ...we hope

Laughter



If not always satisfied, at least OP1 appeared to be confident in taking any concerns she might have had to the residents' meeting (a monthly group meeting with an open agenda set up by the care home for the residents). In this context I explored further why OP1 had brought up the male carer incident in the review:

I: You did talk about a time when a male carer came to help you with a bath. Do you remember that?

OP 1: I think it was a bit of fun

I: Right

OP 1: I think he was just pulling my leg or trying me out

I: OK, I just wondered whether

OP 1: 'cos some of 'em do have the men to bath them, but I don't fancy it somehow

I: I just wondered whether, as you brought it up, that was that was something that you wanted ...

OP1: Oh, it didn't bother me

I: CM1 to do something about?

OP1: It didn't worry me in the least

I: No

OP1: I just told him straight

From this account, OP1 appears to have brought up the incident almost out of 'bravado', in that she wanted to present herself as someone capable of fighting her own battles ('It didn't worry me in the least' / 'I just told him straight'). However, there might have been a degree of *post hoc* rationalisation in the retelling, because in the review, OP1 appeared to expect more of a response from CM1 than she actually got. However, it did highlight the fact that, whatever the reasons behind raising that particular incident, older care home residents might simply want to get certain things off their chest in a review and might not always wish to have what they share recorded or acted upon by the reviewer. Looked at in this light, despite the fact she was a care home resident, the review (and subsequent interview with me) provided OP1 with an opportunity to project an image of herself as somebody who was both capable and independent. This illustrated how, although notionally an 'empowering' process, reviews inevitably remind older people with capacity of their 'client' status and, therefore, of their relative powerlessness. Some chafing and resistance to being thus 'clientised' was to be expected, for example:

CM1: Yeah, I read in your notes

OP1: Hmm – oh you did?

OP1's tone of voice managed to convey a hint of criticism that she was being read up on without upsetting too much the overall 'cheerful' and business-like tone of the review. Occasionally, without being asked, OP1 brought up some aspect of either her past or current life which was not obviously part of the review agenda. For example, although CM1 did not ask about how OP1 had come to be admitted to the

home, she nevertheless brought up the subject, which conveyed that she was not there by choice:

OP1: And I was brought here unbeknown to me you see. I was in hospital and it was all done while I was in hospital

CM1: Right

OP1: So I came from hospital here

CM1: Did they discuss it with you?

OP1: No. Never had a chance. The doctor said I wasn't to go home

CM1: They should have still discussed it with you. You should have options you know, where you were going and why.

OP1: No I never had, never had the option but, anyway, really it was all done for the best

CM1: Uhm

OP1: I always say I'd never put my mum in a home. And I wouldn't have done

CM1: No

Whatever OP1's intentions were in bringing up current or past issues (possibly to feel less 'processed' or simply out of a need to tell her story), the fact remains that CM1's approach provided OP1 with little or no encouragement to talk about them. For CM1, they appeared to be mainly regarded as diversions from getting through the form. Thus, OP1 was not allowed to disrupt the predominantly bureaucratic nature of the process. Most of OP1's 'participation' had been voluntarily passive, however, when she 'participated' more 'actively' either by raising her own issues or

by talking in more depth about a subject of her choosing, her passivity was restored by CM1's management of the review. CM1's chief technique in this respect was changing the subject by moving on to the next question, which proved effective. For example, with OP1 still reflecting on the male carer incident, CM1 moved directly on to then next question:

OP1: Thinking. I think he was only pulling a leg I think. Think he was just trying it on to see if I...

CM1: He knew you'd react

OP1: What I felt about it.....

CM1: What about the rest of the home? The grounds and the actual building downstairs, all the rooms – are you happy with all that?

I interviewed two other older people with mental capacity (OP4 and OP5). Like OP1, their reviews also consisted of just them and the reviewer. They both described the review experience as being asked 'lots of questions'. However, they both struggled to remember any of the specific questions that were asked and also failed to identify anything that had changed as a result of their reviews. I had not observed these reviews so I was unable to prompt them with anything. However, they also wanted to make it abundantly clear in my interview with them that they *did not want* anything changed, because they 'were 'happy' and, like OP1, 'had no complaints'.

Therefore, three older people with capacity expressed the view that, overall, their review was of little value to them. However, they also wanted to convey that, in any

case, this was because they felt that everything was satisfactory. All three also appeared, in the main, to understand their reviews as being about whether they 'had any complaints'. Therefore, their eagerness to say that they 'were happy' appeared to relate to the fact that they did not want to be constructed as 'complainers' and any negative ramifications that this might bring with it. Equally importantly, they seemed to be worried that if they did say anything that might be construed as a complaint, it would be passed on and might have unwelcome consequences. OP5, for example, told me several times that she was happy and that she 'didn't want to move'. In fact, OP5 moving was never on the agenda. Nevertheless, however the purpose of the review was explained to them, it appeared that OP5 saw it as a meeting where being moved from the home was a distinct possibility.

Therefore, the older people with capacity adopted a cautiously passive role in their reviews. There appeared to be various reasons for this which included: a lack of full understanding of both the process and the purpose of the review (for example, mainly seeing it as an exercise to see whether they had any complaints) ; a lack of trust in the reviewer not to take actions that would have undesired consequences (such as being moved from the home or being labelled a complainer); an awareness that the review was being conducted more to meet bureaucratic needs rather than their needs and, overall, an awareness that they were not in charge of their review. The fact that, in each case, the reviewer had no previous relationship with the older person might also have been a factor in the extent to which they trusted them. Lastly, paradoxically, adopting a mainly passive role was a technique by which the older people could control, or at least limit, what the reviewer did thereafter. Stating that they had no complaints gave the reviewer no reason to cause potential trouble for

the older person by taking further action. Therefore, for various reasons, the adoption by the older person of a largely passive role, eased tensions and enabled the system to work for all parties – including the older person. There seemed to be a tacit agreement between both older person and reviewer that the review should not allow the *status quo* to be disturbed. This approach provided a pragmatic way forward for both parties, albeit for different reasons.

When OP1 occasionally 'threatened' to become active (by raising her own issues), the reviewer managed the review to restore passivity, thus reducing any troublesome implications in terms of time and actions needing to be taken. Significantly, the return to passivity did not appear to be particularly problematic for OP1 because rather than see it as a denial of rights or as being ignored, it was interpreted positively as evidence of her ability to look after herself. Although, ultimate control of the review lay with the care manager, for different reasons, both parties exercised their discretion, pragmatically, to ensure that the review did not create unwanted problems.

### **The 'participation' of older people lacking capacity: cautious, passive and irrelevant?**

When reviewing the care of older people lacking mental capacity, care managers evidently felt it was good practice to meet with the older person at some point during the review. However, this created a challenge for care managers of how to engage with the older person and how to bring them into the process. Equally, as far as they

understood who the reviewer was and what was going on, the older person was presented with the challenge of how to make appropriate responses. OP2 had dementia, yet CM2 felt it was important for OP2 to be included in his review in some way ('the respect of actually consulting him'). However, the first minute of what was, in total, an encounter lasting only just over five minutes illustrated the difficulties both parties had in making it a meaningful experience.

CM2: I don't know if you remember me, my name is [name].

OP2: Yes, yes

CM2: I used to come and see you

OP2: Yes, tha...

CM2: and Mrs OP2.

OP2: That's right yes

CM2: And, you know, what I'd like to know is, you know, how you are and... whether you like it here

OP2: Reasonable enough

CM2: What's the food like?

OP2: er, decent enough

CM2: Decent enough? Yeah. Is there anything that you like in particular about here?

OP2: I don't think so, no or not right come to that

CM2: No. Good. Have you seen the football lately?

OP2: On and off

CM2: Arsenal are at the top of the Premier League

OP2: Yeah

CM2: I know you like Arsenal

OP2: Oh yes

CM2: Thought you might be pleased about that?

OP2: Yes – never disappointed when they're there

CM2: Yeah, good. So, have you got any aches and pains?

OP2: No. no, no

CM2: Erm

OP2: No, not really no

CM2: Yeah, I'm wondering actually, how the staff are, you know, how you're finding members of staff

OP2: I don't think I have any problems

CM2: Right. Are they, are they nice to towards you? Are they kind?

OP2: Oh they're kind enough yes

From observation alone, it was hard to gauge OP2's level of comprehension of what was taking place around him (his wife, who was mainly silent throughout this part of the review, said later that he would not have understood what was going on). Whilst he was not staring blankly into space during this part of the review, neither was he engaging in eye contact with CM2. Texts on dementia care highlight the difficulty that



people with the disease have in concentrating particularly with changes of topic (Morris and Morris, 2010) and CM2 changed the topic frequently in his attempts to connect with OP2. For whatever reason, the formulaic nature of OP2's replies suggested that, if not a total lack of comprehension, there was a cautious unwillingness to be drawn, for example, 'reasonable enough', 'decent enough', 'kind enough'. Throughout the remainder of the 'discussion', if anything, OP2 became more monosyllabic. When CM2 asked him 'Have you got any questions?' he replied 'not really, no' and when CM2 asked OP2 'is there anything that you like in particular about here?', OP2's response was equally vague and defensive - 'I don't think so, no or not right come to that'. It appeared strongly as if OP2 just wanted to say whatever was appropriate in order to deflect from further questioning. Unlike OP1, whose defensive approach was calculated, OP2's guardedness seemed to be more based on instinct. OP2 just wanted to shut things down, either to preserve the *status quo* or to protecting himself from failing to perform satisfactorily.

OP3's dementia was such that she could not have coped on her own in the review which is one of the main reasons CM3 asked the relatives to attend. In fact, OP3's relatives felt that, as with OP2, she would not have really understood what the review was about. Many of OP3's responses were similar to OP2's in their defensiveness, in that she was generally either very brief ('yes'), non-committal or had the air of someone wanting to agree with what other people were saying regardless of what it was. Whether it was the aphasia associated with dementia (Morris and Morris, 2010: 144) was hard to tell from this single observation. However, it was easy to see how OP3's performance of mainly appropriate responses in the review could create, superficially, the appearance of understanding more of what was going on than she

actually did. Unfortunately, for OP3 this approach was not always successful. For example, one of her first responses in the review provoked, albeit good-natured, laughter at her expense which probably only added to her becoming more guarded as the review progressed.

CM3: So, how do you think you're getting on at the moment?

OP3: Stationary

CM3: Stationary – *laughter all round* – what, you tell me a little bit more about that. You tell me what stationary means?

OP3: Well, I feel quite well really

That exchange and OP3's difficulty in finding the correct word illustrated how difficult it was for an older person who lacked capacity to fully grasp the appropriate linguistic and social norms applicable to a review. In any event, compared to OP2, OP3 had a more complex task in negotiating the review. There were more people at her review trying to engage with her and, at times, talking over her. Also, some were known to her and some were not. Faced with this challenge, her responses tended to be almost always the same – either 'yes' or a brief compliment such as 'that's jolly nice'. For example:

Rel 2: And then you worked at XXX Orchard – didn't you, OP3, in the garden centre when you retired?

OP3: Yes

Rel 2: OP3 worked until she was 70, 71

OP3: Yes

Rel 2: *[sotto voce]* Then she got Alzheimers

CM3: And then the memory started to play up

OP3: Yes

CM3: That was when you came to live here

OP3: Yes

CM3: And I think, on the whole, it seems to have worked very well

OP3: Yes I do

CM3: But there are, sometimes little things that come up, like when CHM3 comes up, we can ask her about the baths. I've got your notes here which I would normally look at when I do a review. I haven't had a chance to have a good go through them yet. It's just a little way of sort of just looking at everything and seeing that everything's ..

OP3: Yes. That's very kind of you

CM3: No, that's part of my job

OP3: Is it?

CM3: Yes, yes. Part of my job is to come round and see that things are going alright. It's nice when they are

OP3: Yes

CM3: But if they're not, that's what we're here for to sort out sometimes..

OP3: That's jolly nice

CM3: Sometimes reviews are quite straightforward and other times they're, they're not

OP3: It's very kind of you

CM3: Sometimes there are simple little things that

OP3: Yes

As explained earlier, the two older people who lacked capacity (OP2 and OP3) were similar in that their behaviour in the review was 'defensive'. They both attempted to mask their confusion by stating that everything was satisfactory, by agreeing with, pleasing or thanking the reviewer unnecessarily. Again, these defensive strategies appeared to be more instinctive than premeditated. Had they have been premeditated, they might have been less formulaic, more skilfully executed and less easy to detect. For example, OP3's comment in response to CM3 whilst she was explaining about what a review was appeared out of context:

CM3: Sometimes reviews are quite straightforward and other times, they're, they're not

OP3: It's very kind of you

In both cases where the older people lacked capacity, it was impossible to know exactly how little or how much they understood about what was taking place. However, it was evident, as the various examples show, that their cautious, guarded, even placatory contributions appeared to confirm a significant degree of confusion and discomfort. Assuming that the older people were experiencing uncomfortable feelings, and if little weight was going to be put on what they said, this raised the question of how the imagined benefits of the older person 'participating' could be shown to outweigh the disadvantages. An interview with one relative suggested that insisting on 'involvement' in certain circumstances could do more harm than good:

I: Let's look at the most recent review then. It involved yourself, the social worker and someone from the home?

Rel 3: Yeah

I: Was your mum present at that?

Rel 3: No

I: No, are you OK with that? Or do you think she should be there?

Rel 3: In a way, and on everyone's defence, if you like, mum is quite paranoid.

Here 'quite' was used in the sense to refer to a woman who had serious mental problems over many years. Rel 3 also raised a broader question about the potentially stigmatising effect of requiring older people to participate in statutory reviews. In her case she said that, for her and her family, having to attend a statutory review served as a reminder that the state was funding her mother's care and that this made them feel she was a 'second-class citizen'. Putting it into context, she explained:

Rel 3: As I say, I've got no complaints, but you're pretty much on your own looking round these places and feeling a second class citizen because you've got no home to sell for and she's got no money, bearing in mind my mum never owed a penny all her life, worked hard as my dad did. My dad was in the war and I feel, my dad was Labour through and through, cut him in half and he'd – 'cradle to the grave' – he believed as a lot of them did in that generation. And I just feel a bit let down.

Although this particular view was not expressed in these terms by anyone else interviewed, it is not unreasonable to suppose that being made the subject of such reviews might be regarded negatively for a range of reasons – not least because the review was associated strongly with the fact of being funded by the local authority. Interestingly, of the reviews I observed, two of the care managers (CM1 and CM2) actually never referred to the fact that the local authority was funding the placement, whilst CM3 only talked about funding because the relatives brought it up towards the end of the review:

CM3: And I always finish up with one little final thing – is all the paperwork alright now, everything, you're getting all the, everything through OK?

Rel 2: Yes

CM3: Yeah

Rel 2: We had an in, we had another, we get yearly ..

CM3: Yeah, you will do yeah

Rel 2: And we had a month ago. Yes. And we were surprised again about that I didn't know about that bit

Rel 1: Oh the financial side?

Rel 2: Yes.

Rel 1: Yeah. There appears to be two thresholds

Rel 2: Now, they told us it was 16, was it 16?

CM3: No it should be 23

Rel 2: What they've told us is there's the 23 and then they would finance. But they've told us now, because when we looked at OP3's paperwork, she was only left with £7 or something

Whilst the fact of being funded by the local authority was obviously a critical factor in Rel 3's views about reviews and Rel 1 and Rel 2 also wanted some clarity in respect of OP3's funding arrangements, issues about being funded by the local authority were not articulated by any of the older people interviewed. However, the fact that the care managers appeared to be quite circumspect in the way they approached the funding aspect of reviews, suggests that they might have sensed others' sensitivities around the issue.

The micro level decisions facing care managers about *who* to involve and *how* to involve them were, therefore, challenging not least because the effects of such decisions could well exacerbate rather than resolve tensions. The degree of discretion available to care managers as well as the particular circumstances of the older person meant that the challenge was not always managed in the same way.

In OP2's review, CM2 had briefly 'involved' him by engaging in talk about sundry matters for a few minutes. In the review report no attempt was made to indicate that OP2 had played any significant part in his review. In fact, in the report CM2 made OP2's lack of ability to participate clear throughout. For example, in the section about choice of bed time:

OP2 gets up at seven in the morning which according to Mrs OP2 would be his normal time at home. He goes to bed at 21.00pm in the nursing home. It appears that there may be little choice in this area. OP2 is unlikely to protest. There is no real way of knowing what time he would like to go to bed.

So clearly did CM2 believe that OP2 was 'unlikely to protest' that, in fact, bedtimes were not even talked about in the review. The comments recorded about what time OP2 got up and went to bed were based on what was known about the home's routines, not on any information provided by either OP2 or his wife. Later, in response to a question on the form which asked whether OP2 was involved in the running of the home in any way, CM2 recorded:

OP2 'is 'unlikely to contribute in a meaningful way'.

Therefore, any tension CM2 might have felt about how to enable OP2 to participate was resolved in the review by not really involving him other than by a few minutes desultory chat and, in the report, by constructing OP2 as beyond any meaningful participation.

In OP3's review, whether it was because she appeared to be slightly less confused than OP2, or because she had been present throughout the whole review, or whether it was because relatives had been in attendance, CM3 used her discretion differently, not only in how she tried to include OP3 more, but also in how she wrote up how OP3 had contributed to the review in the report.



OP3 had dementia, was prone to confusion and her extremely poor short-term memory meant that both her relatives and the care home manager were cautious in how much they took what OP3 said at face value . However, when interviewed, CM3, who was fully aware of OP3's cognitive limitations, expressed the view that OP3 was 'a good advocate for herself'. This appeared to be mainly based on the fact CM3 had enabled OP3 to identify two aspects of her life in the home where she wanted more choice (choice of menu and choice of bath time). For example, the menu issue which was discussed in the previous chapter 'emerged' as CM3 worked through the form:

CM3: And are you eating well?

OP3: Yes

CM3: What's the food like here?

OP3: It's quite nice

CM3: It's quite nice. You enjoy your food? And when it gets to dinner times, can you choose what you have?

OP3: No

CM3: You can't? No

OP3: I don't think so.

CM3: No. Well we can ask them if there's a choice, because sometimes, what if there's something you don't like?

OP3: Well I have to leave it

CM3: Do you? Do they, do you get something else?

OP3: No

CM3: No. Oh, we can ask them about that.

When CM3 later asked the home manager about it, it transpired that OP3 *did* choose her meals, but then forgot what she had chosen. This was also confirmed by her relatives. However, although it was not the exact issue that OP3 had raised, CM3 opted to record it in the review report (see below). This, therefore, demonstrated 'officially' that OP3 had been involved and that her 'participation' had led to some 'action' being taken on a related issue:

"OP3 is very happy at The Elms. She likes the staff and says they are all very nice to her especially the activities co-ordinator. She likes the food but said she did not get a choice of meals. In discussion with CHM3 residents pick their meals for the week from a menu on a Sunday. OP3 does not remember what she has chosen so CHM3 agreed to ask staff to give her a copy of her menu for the week once she has made her choices."

At the conclusion of the report CM3 identified 'an action point' for the home on this issue. In so doing, this served to make OP3's participation appear more meaningful because it looked as if it would have a practical consequence:

'The Elms to arrange for a copy of her weekly menu to be given to OP3'.

When interviewed afterwards, CHM3 explained how the home had not yet responded on this point. She also talked more about some of the problems with meeting OP3's needs in that area based on caring for her for over three years:

CHM3: the menu thing, which, obviously we're trying to find a way to implement that that OP3 will find useful. Because you can give her a piece of paper and she will put it down and she won't know where it is the next day. So, unless a carer is able to go and find the piece of paper and say this is your, this is your menu for this week OP3, it's not going to be effective is it?

I: No

CHM3: We did think about a board, on her wall, you know, how about we write down what you've ordered. That might be a way round it. So, but yes, we haven't yet implemented anything yet. Lots of thoughts about it.

It appeared that implementing CM3's action point in a meaningful way would prove more challenging than the report suggested. In some respects, it illustrated that CM3, who knew OP3 least well of those involved, was at a disadvantage in how far she could fully understand OP3's situation and therefore realistically promote OP3's best interests. She had to rely on the cooperation of others. When he was interviewed, Rel 1 put the issue more clearly into context from his perspective.

Rel 1: And, and yet, we were talking how, she talked about her food didn't she? About the menus and things. Mum hasn't got a clue of within five minutes of you saying something to her what you've actually said. If she made a decision on something, a choice, she wouldn't know that she'd made that choice four or five minutes later. So that didn't seem to be that relevant

In a sense this was a 'manufactured' review issue in that it was not telling either the home or the relatives anything about OP3's situation that they did not already know. In the event, CM3 expressed no intention of following up the action point she had recorded. It appeared that the real point of the exercise, in contrast to CM2's construction of OP2 as beyond meaningful participation, was to construct OP3 as a meaningful participant in her own review. CM3 had enabled OP3 to help identify an issue and the record could therefore show that OP3 had participated and that the review had been 'needs-led'.

This whole process with OP3 was interesting to observe because it provided a good illustration of how review participants other than the care manager exercise discretion in what they do that might affect the older person. Clearly, as discussed in Chapter Six, neither the relatives nor the care home manager considered the issues raised at the review as either new or pressing in terms of making a difference to OP3's quality of life. However, they appeared to understand tacitly that CM3 wanted OP3 to be able to 'participate' in some way and that CM3 also wanted something on the record to show that OP3 had 'participated'. It cost the relatives nothing to have CM3 record two contributions from OP3 that demonstrated she had apparently contributed. It also meant that OP3 was not contradicted in the review itself, which would have been potentially humiliating for her and would have created more, unnecessary, tension. The relatives therefore went along with the process. The choice of menu issue illustrated how CM3 exercised her discretion in constructing the appearance of participation, both in the review itself and in the report. Other

participants, for example, CHM3 would use their discretion in how much time and effort went into dealing with it subsequently.

Any control OP3 might have had over the whole process was non-existent. In the spirit of 'participation', she had been encouraged to answer a question which had subsequently been turned into an action point which, whilst related, was slightly different from the point she made and about which the care home manager was still thinking how to respond. Unlike OP2 who was constructed as unable to participate meaningfully, OP3 was. However, neither of them had any observable control over either the review process or the outcome. In both cases where the older person lacked capacity, the older people provided a blank canvas on which the reviewer could, according to their discretion, construct a picture of what sort of participant they were.

### **Conclusion: the role of older people in their reviews**

In Chapter Five it emerged from the interviews with various stakeholders in the review system that care home reviews were occasionally used by care managers, relatives and care home staff to produce changes that affected older people in care homes. It presented a picture that decisions were made about the older person by other actors without necessarily involving them.

In the small number of reviews actually observed this picture was broadly confirmed. However, their 'non-participation' was more complex than the older person being

simply ignored in each case. Overall, the role played by the older person varied depending on different factors, for example, their mental capacity, the circumstances and who else was involved. However, there were characteristics common to the three reviews observed. None of the reviews was initiated by the older person, yet they were obliged to go along with review arrangements decided by others. In this context, they displayed various degrees of guardedness and caution in response to questioning. These observed dispositions suggested that the older people felt powerless to exercise any control over the process.

As discussed in Chapters Five and Six, the review system was driven by multiple, often conflicting, agendas which created tensions for those responsible for making the system work. The most obvious cause of tension was for the local authority in balancing review quantity with quality. It appeared that the potential for tension was reduced when the older person either adopted voluntarily or was placed in a role of passive participation.

In this case study, where the older person had capacity and, therefore, the potential for agency in the process, her passivity was more actively managed by the care manager. She 'participated' in the sense that she was cast in the role of principal informant on a range of pre-structured questions. When she deviated from the tightly-controlled format and introduced her own issues, the reviewer was able to ensure that this did not disrupt the business-like progress of the review and any contributions outside of the format were not recorded. As a consequence, the record showed that the older person was 'happy' and no extra work was created for either

the care manager or the care home. However, this could not be construed as a straightforward denial of 'rights' or 'voice', as it appeared that the older person more or less understood the rules of the game and her main contribution was to confirm that she was happy and had no complaints. In this case, her participation was passive, partly through choice and partly through the way her contributions were managed.

In the cases where the older person lacked capacity, their passive participation remained an important requirement because it enabled care managers to pursue their more 'tick-box' (quantitative) agenda whilst, notionally, working according to the (qualitative) ideals of service-user 'involvement' with the minimum of conflict. However, the two older people who lacked mental capacity experienced different treatment. One was considered unable to participate meaningfully and the conduct of the review and the subsequent report reflected this. The other was constructed as someone who could participate, at times, in a meaningful way and this, too, was reflected in the conduct of the review and the subsequent report. The observations also revealed the variations in care manager competence in communicating with people with dementia. Some of their practices, such as quickly changing the topic of conversation, appeared to be well intentioned but unwittingly disempowering.

Care managers used their discretion throughout the process, including in how the review was recorded. In the three reviews observed, they played a central role in ensuring that the older person's participation, where it took place, was, essentially, passive. However, it would be inaccurate to say that it was the care manager's role

only. Whatever the review, it was functional for the different stakeholders if the older person was a passive subject. This enabled everybody (including the older person themselves) to minimise any potential conflict they might face, whether this was in maintaining an established view of who the older person was; in being able to do things according to preferred and familiar practices; in saving time or in avoiding any 'unnecessary' trouble. In this case, older people who had mental capacity, even if they did not necessarily quite feel it in the moment, came to realise that their review was a bureaucratic necessity ('lots of questions') and professed, when interviewed subsequently, to have placed no real value on the experience.

The tacit acceptance by all parties that this was the role the older person should play meant that the possibility of any additional tension in the system was diminished. It is for this reason that the passivity or docility of older people in reviews could be thought of as 'system induced' rather than the responsibility of any single actor.

This Chapter, together with Chapters Five and Six has reviewed the empirical evidence from observations, interviews and documentary sources in order to identify key characteristics of how the system of statutory care home review operated in the County. A major theme that has emerged has been the, often pragmatic, exercise of discretion by all review participants (including the older people as has been discussed) to reduce tensions inherent in the system. In Chapter Eight, returning to the framework provided by Lipsky, I expand upon the idea that the use of discretion in what happens in the care home review system is not simply confined to care managers and discuss how it is dispersed amongst the various actors and exercised



in various ways. In Chapter Nine I discuss more fully and more critically the difficulties I experienced in gaining access both to care home reviews to observe and to older people to interview. Both discussions illustrate well 'dispersed discretion' at work providing insights into the operation of the care home review system in the County and the, largely, system-induced passive role played by the older people within it.

## Chapter Eight: Discussion

### Introduction

This chapter has three main sections. It begins by summarising and discussing the key themes and findings emerging from the previous Chapters in relation to how they helped answer the questions specified in the first three research objectives set out in Chapter Four. In the second section the discussion then moves on to a critical consideration of the fourth and final research objective which was to assess the relevance of Lipsky (1980) as a conceptual lens through which to analyse and explain the practice of statutory care home reviews, particularly in respect of the use of discretion. The exercise of discretion by the primary street-level bureaucrats in this case (locality care manager) is considered critically. However, the discussion develops further the ideas introduced in Chapter Three that, in the context of a public sector in the UK where power is now more dispersed amongst various statutory and non-statutory actors, the concept of street-level bureaucracy, as it was originally developed by Lipsky, needs to continue to be updated and refined to take into account that the exercise of discretion is no longer the sole preserve of front-line practitioners employed in public organisations, but dispersed unevenly throughout a much more fragmented system. As part of this discussion I engage in a critical dialogue with Evans's critique of Lipsky (2010a and 2010b) and propose that in going 'beyond street-level bureaucracy', as well as managers at all organisational levels, non-statutory actors (such as care providers and relatives) also need to be included in any analysis of how discretion is exercised in the adult social system review system.

To complete the discussion, the third section focuses on the situation of the older person who is at the centre of the statutory care home review but who, for various reasons, is also the least powerful actor involved. I argue that review practices, far from being a means of empowerment for older people, can, paradoxically, often end up becoming a source of disempowerment, if not oppression. Some suggestions are made that could improve the review experiences of older people and ensure that their interests are better promoted. However, in making these suggestions, it is recognised that they would be unlikely to be effective unless there was significant change in the overall way the adult social care system operates.

### **Lessons learned about statutory care home reviews in the County.**

In Chapter Four I explained that the overall aim of the case study was “to obtain an understanding of how the system of statutory care home reviews operated and was experienced by those involved in it”. The first three specific objectives were:

- To explore and explain the various purposes that statutory care home reviews serve in terms of both policy and practice.
- To examine and compare different stakeholder perspectives on the review process; for example, managerial, practitioner; service-user, relatives and care home staff.
- To observe, in particular, the roles of the reviewer and the older person in the review process.

The findings that were discussed in Chapters Five, Six and Seven substantially answer these questions. To summarise key points briefly, it was found, firstly, that

there were different ideas amongst the various stakeholders about the purposes care home reviews served. Reviews were found to fulfil multiple purposes ranging from serving bureaucratic needs (delivering on nationally or locally set performance targets), to establishing value for money, and to safeguarding residents in care homes where standards of care were considered poor. Much also depended on the circumstances in which the review was called, for example, care home managers may have seen reviews as a means of securing additional resources or asking for a resident to be transferred in circumstances where the older person's condition had degenerated. Initial reviews following a hospital discharge appeared to have a particular significance in this respect. Relatives could initiate reviews if they wanted a transfer of care home or to lodge a complaint. However, care home residents with capacity saw them largely as method of discovering whether they had any complaints.

Few of the stakeholders interviewed felt that the system was working well. Managers were aware that to fulfil organisational targets, within a context of scarce resources, compromises needed to be made on quality. The telephone review exemplified such a compromise. With reviews generally, managers were aware that they mainly had to trust that practitioners' practice conformed to the required standards, however, at the same time, they were also aware that practitioners did not always understand what they were supposed to be doing. Practitioners were, at times, self-critical about their own and others' practices, sometime admitting that they lacked the specific knowledge, training or background to do the job properly. The actual practices observed in the reviews varied, demonstrating that the format was open to widely differing interpretations by individual practitioners. There seemed to be a significant

gap, at times, between practice 'talk' (again, with variations between practitioners) and some of the practices actually observed in reviews. For example, whilst different care managers talked about their review practices in terms of checking the care plan, upholding rights, meeting needs, offering choices or promoting participation, actual review practices were observed where issues of choice, dignity and rights were being overlooked. Whether care managers involved the older people in review decisions in any meaningful sense was also open to question.

In Chapter Two, reference was made to the 'intensification' of social work where, as Harris and White (2009) state:

Performance indicators, and measurement of outcomes against them, often seem to dominate the experience of contemporary social work (p.166).

There were strong echoes of this in how reviews were carried out in the County. For example, the need to get through a high volume of work appeared to leave practitioners with little time or inclination to dwell too long on any particular issues an older person or a relative might present. Both practitioners and managers worked within a challenging performance culture that required them to balance the need to maintain care standards laid down in national policy with the need to deliver a level of 'throughput' also demanded by national and local policy. This balancing act was complicated by continual organisational change brought about for different national and local reasons. At the same time, there was a need to implement several policy initiatives which were often conflicting, ambiguous and open to different interpretations; for example, personalisation, safeguarding and issues relating to

mental capacity. Therefore, it emerged that, within the context of both change and intensification, the care home review system was characterised by the need to compromise at every stage.

From the perspective of the care home, one care home manager thought that reviews were necessary so that the local authority could satisfy itself that it was getting value for money. A common complaint from care home managers was that procedures were not followed consistently and that the system could be unresponsive when a review was wanted by the care home to help ensure that a resident's needs were met appropriately. Another care home manager thought that the review format was more designed to elicit the negative rather than celebrate the positive aspects of care home living. This illustrated a more general point that, with many potential stakeholders involved in care home reviews, communication between the parties was sometimes less than satisfactory and militated against a shared understanding of what purpose they served. Relatives tended to see reviews as a mainly bureaucratic ritual and as a necessary price that they and their elderly relative had to pay for being funded through the local authority. One highlighted the potentially stigmatising effect of such a process. Another highlighted the fact that reviews could be an emotionally uncomfortable space for both the older person and their relatives – a point not always appreciated fully by professionals. As far as the older people themselves, whether they had or lacked mental capacity, there was little evidence that they were meaningfully involved in the process. As explained in Chapter Seven, their position could be characterised as one of 'passive participation' at best and often marginal, if not excluded completely, in many key aspects of the

review, for example, on decisions about being moved which could be instigated by relatives or care homes.

The fieldwork highlighted several sources of tension for those working both in statutory social care departments and care homes and also revealed that the exercise of discretion was essential in order to resolve the many tensions inherent in the system. With the focus on the exercise of discretion, in the next section I will concentrate the discussion on my fourth research objective which involved assessing the relevance of Lipsky (1980). What follows is a critical dialogue with selected critiques (e.g. Postle, 2001; 2002 and Evans, 2010a and 2010b) around the relevance of Lipsky's theory of 'street-level bureaucracy' in understanding statutory care home reviews.

### **Assessing the relevance of Lipsky**

In full, the final research objective stated in Chapter Four was:

- To assess the relevance of 'street-level bureaucracy' (Lipsky, 1980) as a conceptual lens with which to analyse and explain the practice of statutory care home reviews, particularly in respect of the use of discretion.

I contend that the foregoing chapters satisfactorily demonstrate that Lipsky is still broadly relevant explaining the operation of the statutory care review system in Britain today. For example, the three observations made by Lipsky (1980) about the operation of street-level bureaucracies outlined in Chapter Three have been evidenced in this case. Firstly, the fieldwork found practitioners coping with the uncertainties and work pressures in ways that meant that their practice effectively

*became* review policy. Secondly, the research found practitioners working within significant resource constraints requiring the use of discretion to resolve the, sometimes, conflicting and ambiguous goals that guided their work. Lastly, it appeared that those working in the system spent their lives in a 'corrupted world of service' in the sense that, despite the existence of professional codes (GSCC, 2010) and national standards (Department of Health, 2003) which guided their work, practitioners and managers tacitly accepted, on a daily basis, standards of care practice that were sub-optimal.

Finding evidence to confirm the broad relevance of Lipsky's framework has not proved difficult. However, there are problems with accepting the concept without significant modifications. Critically, Lipsky was writing in a context where the public sector in both the USA and UK was expanding. This implied an expansion of state run agencies. For example, he wrote that:

The public sector has absorbed responsibilities previously discharged by private organisations... (Lipsky, 1980: 6).

However, as discussed in Chapter Two, the adult social care sector in the UK has undergone successive, neo-liberal informed transformations since the 1980s. This has led to the contraction of state-run social welfare provision and an expansion of a diverse independent social welfare sector. Many of the responsibilities that the public sector might have absorbed over previous years have either been shifted back to citizens and their families or have been contracted out to private and voluntary organisations. This has, by necessity, been accompanied by the introduction of more



complex regulatory arrangements. Therefore, the context in which social welfare is 'delivered' in the UK has changed significantly since Lipsky first developed the theory.

### **Multiple stakeholders: dispersed discretion**

For Lipsky, street-level bureaucracy took place in the interface between front-line workers in public welfare organisations and the citizen. This was based mainly around a uni-directional power relationship where, even if it was difficult to hold street-level bureaucrats to account, respective roles and responsibilities were relatively clear. However, the transformation of the public sector in the UK has not only dispersed state power, it has dispersed responsibility and blurred accountability. The increasingly dispersed nature of power in adult social care brought about by the processes of marketisation, privatisation and modernisation highlighted in Chapter Two is reflected in the dispersal of discretion amongst multiple actors. This point is highly relevant because, in the statutory care home review system, the exercise of discretion was found to be not just the sole preserve of a single group of street-level bureaucrats (in this case, local authority care managers), it was dispersed, albeit unevenly, throughout the system.

Without downgrading the critical role played by care managers, as described in Chapter Six, the exercise of discretion was found to be more complex, being dispersed amongst multiple actors both from within and outside the statutory care sector (including managers, private care providers, relatives, and even, to some extent, the older person) who exercise it in different ways. In this analysis, the

discretion exercised either individually by each actor, or by actors in combination with each other, is not just a linear, uni-directional arrangement where there is no power, for example, to modify or resist demands. It was found that, even though power was unevenly distributed, the way the discretionary decisions made by the different participants impacted on others, made it more of a circular process.

Depending on the circumstances, different review actors were able to use discretion in different ways; to comply with, modify, deflect, resist or ignore a request made by others if an issue highlighted for action did not fit in with either their priorities or their perception of the issue. This was seen in Chapter Six, for example, with CM3's suggestion that OP3 be given a menu. When interviewed three weeks later, CHM3 was still having 'lots of thoughts' about it' and the relatives, seeing no point in OP3 having a menu, let the matter drop without further comment.

Consequently, it emerged that whilst care managers were inevitably central figures in reviews, in that they had most power over how the review was organised and how it was recorded, it was found that their power to elicit certain responses or to set action points for others could also be effectively neutralised by relatives, care home staff and even the older person on occasions depending on how they construed the reality of the situation. An issue raised need not become an 'action point' and an action point recorded need not necessarily mean an action point undertaken.

Therefore, the micro-power relationships in reviews were not simply uni-directional they were multi-directional, complex and contingent.

It was also found that decisions about *who* was involved in a review was contingent, largely but not exclusively on decisions made by the care manager. However, even if invited to attend, that did not guarantee attendance as the care managers pointed out. One care home manager said that the care home would have a representative at reviews, another said that they only attended if invited.

Increasing the number of review participants multiplied the number of perspectives and broadened the range of issues they might potentially be raised. Any issues raised in reviews, by any of the parties, implied that other participants might be required to take some form of action. However, accountability for making sure that any actions took place often appeared to be blurred. Analysis of review observations and subsequent interviews with participants suggests that reviews need to be seen as a process of negotiation between actors, but not necessarily one either arising from or culminating in a shared reality. Analysis of the field data revealed that different participants came away from reviews with, sometimes, quite different perceptions about what had gone on, what should be done and the meanings attached to specific questions and answers. An equally interesting and not unrelated point was finding out that different actors were not necessarily aware of each other's emotional reactions to what was going on. For example, relatives talked of guilt in reviews and even stigma but this was apparently not picked up by care managers or care home staff.

Reviews could consist of as few as two people, unless the older person lacked mental capacity in which case a family member could be involved, notionally to

represent their interests. Whether mental capacity was a factor or not, reviews in which there were multiple perspectives represented became a potential contest of knowledge about who knew the older person best and what was in the older person's best interests. This need not necessarily be family members, as might be supposed. Family knowledge might be superseded by care home staff who could claim to know the older person as they now were. These factors appeared to affect the way that discretion was used to prioritise issues or whether to follow 'agreed' plans or not. Care managers might have overall responsibility for the process and outcome of reviews but the greater the number of participants involved, the less control they risked having over either the process or the outcome.

An examination of the micro-dynamics of care home reviews showed both complex interactions involving the, often, subtle use of discretion by participants. However, reviews take place in the broader macro context of an increasingly complex and dispersed public sector, the boundaries of both power and responsibility between purchasers, regulators and providers and the public and private spheres have become much more blurred and, according to evidence from the fieldwork, also less well understood by those involved. Care home reviews take place in this transformed world of public services where power (and therefore discretion) is more dispersed. It is, therefore, not simply a question of determining *whether* discretion is used in implementing review policy, but also what factors shape the ways in which different actors use discretion, what are the ends to which discretion is exercised and with what consequences?

## **Discretion: dispersed and multi-layered**

In Chapter Three I cited Evans (2010a and 2010b) who argues that we need to go beyond Lipsky's original formulation of street-level bureaucracy as a predominantly front-line activity. Evans (2010a) problematises Lipsky's original study, making the point that:

The unanticipated policy outcomes that Lipsky ascribes to street-level bureaucrats are more likely to be the result of a complex, multi-layered and multi-actor process than the result of the actions of one group of workers (p.18).

Echoing Evans' sentiments, I will endeavour to identify how and why key actors in the review system use their discretion and, in doing so, expose some of the layers of process in which care home reviews are enfolded.

## ***Managers and Practitioners***

As highlighted in Chapter Three, the local authority social services departments of the 1970s were described as 'bureau-professional regimes' (Clarke and Newman, 1997) where a degree of professional discretion was possible within the constraints of bureaucratic rules and hierarchical organisational structures. In many ways, the 'bureau-professional' was exactly the kind of worker upon which Lipsky based his ideas about street-level bureaucracy. However, the processes of managerialisation to which social services departments in the UK and in Europe have been subject since the 1980s onwards have brought about a re-evaluation of Lipsky's theory.

Much of the subsequent debate around Lipsky has focused on whether managerialism has effectively curtailed practitioners' ability to exercise 'professional'

discretion in the ways that Lipsky proposed (Howe, 1991; Jones, 1999; Postle, 2001, 2002; Evan and Harris; 2004; Evans, 2010a and 2010b). The findings from these various studies generally support the cautionary warnings made by Clarke *et al* (2000) that, while managerialism is a powerful set of beliefs and processes, when put into practice, 'it' does not work evenly, coherently or in a uniform way in every organisation where it is introduced. The impact of managerialism varies according to many factors and, in any organisation that has undergone processes of managerialisation, there can be different modes of adoption, adaptation and resistance (p.8). Postle (2001), for example, found evidence that some team managers were apparently resistant to the reductionist brand of managerialism they were expected to implement and worked round the system, incorporating elements of more traditional professional supervision in their management style.

In this context, Evans and Harris (2004) and Evans (2010a and 2010b) draw a broad distinction between 'domination' and 'discursive' perspectives on managerialism. For Evans (2010a), writers like Howe represent the 'domination' perspective in that, by arguing that processes of managerialisation in social services have effectively curtailed professional discretion, such writers construct managers as a homogeneous group whose loyalties unequivocally rest with their organisation's desire to systematise and routinise social work at the expense of professionalism. In contrast to this, the 'discursive' perspective' put forward by Evans (2010a):

Locates managers at the intersection of discourses of power which define their role and their relationships with the street-level staff they supervise in very different ways: managers may or may not subscribe to managerialism; they are likely to be

struggling with and operating within discourses of professionalism as well as managerialism (p.43)

Evans (2010a: 25) criticises both Lipsky and the 'domination' theorists for characterising managers purely as obedient and committed implementers of policy delivered pristine from on high. He argues that to understand fully how discretion is exercised in shaping policy implementation in organisations, managers should not simply be seen as homogeneous 'policy lieutenants'. Evans proposes that we need to understand how discretion percolates down through organisational hierarchies and argues that we must therefore broaden the focus of enquiry beyond the 'street-level' to encompass different types of manager and different layers of management in different parts of the organisational hierarchy. The findings from my empirical research would bear out Evans' point that managers are, therefore, significant policy actors in themselves and how they decide to interpret and implement policy, will be influenced by both their organisational and professional loyalties. Such loyalties, he argues, are likely to reflect whether managers work closer to the 'centre' of the organisational hierarchy, for example, performing a more senior strategic or operational role or whether they work closer to service delivery, for example managing or supervising locality teams. Evans therefore proposed a more nuanced analysis of the impact of managerialism on social services departments. From this perspective:

Managerialism.....is seen as reconstructing professional discretion rather than abolishing it (Evans, 2010a: 53).

One important reason for this, Evans argues, is that 'allowing' practitioners to retain some degree of discretion enables managers to shift responsibility for resolving some of the dilemmas of street-level bureaucracy, a key dilemma being balancing the desire for quality with the demand for quantity outlined extensively in preceding chapters. It was found from talking to managers in the County that this certainly appeared to be the case. At the senior level, this was articulated in more abstract terms, by the idea of a 'conversation' that practitioners would need to have around certain problematic issues. Closer to practice, the team manager (LTM) expected reviews of a certain standard but did not want to know in any great detail how this was achieved. Even closer to practice, the senior social worker, only too aware of the compromises made in review practices, reluctantly had to 'trust' those she supervised to do a good job, aware that this did not always happen. At this level, the tension felt within that manager was palpable. This demonstrated that the point made by Lipsky (1980, pp. 140-156) that 'resolving' dilemmas in street-level bureaucracies has a psychological cost on those that work in them, applied not only to street-level bureaucrats but their managers as well.

Evans (2010a) draws the conclusion that:

The relationship between social workers and their local managers is more complex than Lipsky's account suggests (p.139).



Evans argues that manager-practitioner relationships become more complex at the local level because of the fact that, being closer to practice, managers at that level are more likely to retain a sense of what constitutes professional practice. Unlike managers higher up the organisational hierarchy, this both interferes with and complicates their ability to adopt a purely managerial orientation. This is the main basis for the complexity to which Evans refers.

In the sense that relationships between managers and practitioners were more complex than Lipsky suggested, Evans' point was supported by the findings in this case study. However, whereas Evans reports as having found significant evidence of professionalism in tension with managerialism – particularly at the local level, I found pragmatism was more in evidence than professionalism. Whilst a sense of what might constitute professional practice was not completely absent, professional principles appeared to be easily compromised in order to get the work completed. All three tiers of management that I interviewed (Development and Policy Manager; Locality team Manager and Senior Social Worker) possessed professional social work qualifications and referred, at times, to social work values when they talked about meeting 'need' or promoting 'choice'. However, they appeared to be much more driven by the need to meet performance targets. They were all aware that compromises needed to be made on professional standards. However, the more remote a manager was from practice and therefore the more shielded from actual the day-to-day compromises that were made, the less acutely aware they were of the consequences of any compromises made. This was illustrated by the senior manager's (DPM) belief that telephone reviews were tolerable with a bit of 'quality around them', whilst care managers were only too aware of their shortcomings from

the service user's point of view and gave specific reasons why they were not appropriate.

I can't see someone, I can't smell, I can't look around where they're living (CM1)

In highlighting the complexities of the manager-practitioner relationship and the tensions caused for both parties which need to be resolved in practice, the critical question is raised of what factors actually guided the use of discretion by the managers and practitioners in this study. At locality team manager and senior social worker level, the absence of any direct observation meant that the effects of poor practice were mainly brought to their attention when complaints were made by relatives or care home staff. Of the three tiers of manager I encountered in the County, the local team manager appeared to be the most acutely aware that her performance in the organisation was judged by numerical targets rather than any other measure of quality. This clearly appeared to affect her style of management which led to creating dedicated review workers in the team, setting review targets and publishing them on the team notice board.

Amongst many others, Postle (2001, 2002) has drawn attention to the tensions experienced by practitioners in putting care management into practice. The reasons for these tensions included the imposition of managerial controls, but also organisational change and ambiguous job goals and all of these factors have been found in the County care home review system as discussed at length in preceding chapters. Unlike many of the studies of care managers cited in Chapters Two and Three, the empirical evidence from this research suggests that *all* levels of staff in

the County, whether manager or practitioner, felt the tensions that came from the pressure to meet organisational performance targets in a policy and discursive context that also emphasised choice and 'person-centred care' (Department of Health, 2001b). Again, Harris and White (2009) link these outcomes to the 'intensification' of work in social services which as described in Chapter Two, has been largely brought about in adult social work by the community care reforms but was further accelerated by New Labour's modernisation agenda. As they argue:

Intensification has been a key theme in modernising social work. It has installed a neo-liberal workplace culture that has stressed performance to targets. However, intertwined with the theme of intensification have been calls for forms of practice shaped by individualised responses to service users, which are at odds with social workers' dominant experiences of instrumentalism (p.168).

Analysis of care home reviews support this argument, in that the pressure to complete work quickly meant that, where they existed, any 'professional' qualms about not providing sufficiently 'individualised responses to service users' had to be suppressed. However, for the purposes of this discussion, I prefer to use the term 'pragmatic' rather than 'instrumental' to describe practitioners' dominant orientation to their work.

### ***Pragmatism over professionalism***

Evans (2010a: 27) claims that professional status could act as a significant factor in the ways in which discretion is exercised, suggesting that there might be important

differences in how discretion is used between professional and non-professional groups and also that:

Shared professional concerns may break down the barrier, which Lipsky suggests, divides managers and street-level bureaucrats. Where managers and street-level bureaucrats share professional concerns, this may lead to cooperation and collusion – not necessarily, as Lipsky suggest on the basis of purely pragmatic concerns, but perhaps also in the pursuit of shared professional commitments (2010a: 27).

As indicated earlier in this Chapter, close examination of the review system suggested that any cooperation or collusion that existed between managers and practitioners was, in fact, largely governed by pragmatic concerns (in the sense of doing the minimum required to complete the task) rather than professional ones (which would more actively set out to promote the core values of social work such as rights, choice, and dignity). Certainly, none of the managers or practitioners interviewed referred to the codes of practice set out by their 'professional' body (GSCC, 2010). The findings mainly supported the observations made by Evans (2010a) in his study, where he concluded that:

These practitioners seem to subscribe to a discourse of professionalism that is framed in terms of the concerns and responsibilities of the organisation.....instead of practitioners seeking to resist management control to defend professional autonomy, these practitioners go beyond accepting organisational priorities; they actively seek a more managerialised work environment and a managerialised mode of practice (p.163).

Evans' observations resonate in this study in that I had no real sense that the managers and practitioners involved felt that they had a distinct professional identity or felt that they were part of a professional body that existed outside of the organisation. For example, the word 'professional' was used only once across the various managerial and practitioner interviews. This was when, having said she did not have the time to read very much in review records, the locality team manager expressed the view that how much was written was down to 'professional judgement'. Otherwise, there were no references to professional bodies, professional codes, professional or even vocational training (e.g. NVQ) or anything that gave the sense that their work was informed by anything other than organisational guidance.

As discussed in Chapters Six and Seven much of the care manager practice was characterised by the expediencies of getting through the review as efficiently as possible. Whilst CM3 created two 'action points' that later appeared to be ignored, CM1 and CM2 effectively declined opportunities to take further several potentially important issues which emerged from the reviews they were conducting. In their accounts, care home managers talked about care managers' review practices being variable. Resistance from care managers to managerial control was talked about more in terms of wanting to resist being given a greater volume of work rather than wanting the time and professional freedom to work in more depth with service users.

The care home review practice by care managers observed in this study appeared to be much more in the tradition of the 'unreflective people processing' found by Postle (2001) than the 'quiet challenges' to managerialism observed by White (2009). If

anything, this study illustrated that, in certain circumstances, managers might have better attuned professional sensibilities than practitioners. A concrete example of this was provided in Chapter Six, where the locality team manager was mindful that the more 'light touch' approach to regulation adopted by CSCI, described in Chapter Two, would leave a regulatory gap. As explained in earlier chapters, 'adult safeguarding' had become an overt national policy in adult social care since the publication of *No Secrets* (Department of Health, 2000b). Statutory social care organisations were given lead responsibility to develop robust procedures to protect and safeguard 'vulnerable' adults. At the same time, the professional duty to protect people from harm and abuse was reflected in professional codes (GSCC, 2010). The locality team manager's awareness of the need to safeguard care home residents properly led her to develop a system whereby reviews were used to collate information about providers that were considered to be providing substandard care. Therefore, although strongly committed to productivity (getting through as many reviews per week as possible), this manager (LTM) exercised a considerable degree of managerial *and* professional discretion and actually created extra work for her team in order to ensure that standards of safeguarding were maintained.

As far as practitioner awareness of safeguarding, not only did one (experienced) care manager (CM2) admit that they were not sure how best to protect vulnerable residents in care homes from abuse, his practice reflected this, for example, ignoring the abuse of dignity suggested by the photographs of OP2 naked taken on admission to the home.

Evans (2010a and 2010b) seeks to understand the impact of professionalism and professional status on the way that managers and practitioner exercise discretion. However, the examples provided in this study indicate that it would be difficult to generalise a simple formula based on either professional status or one's respective position in the organisational hierarchy. The use of discretion in this study was found to be contingent on a range of mainly pragmatic rather than professional factors. The discretion used in decision making could, to a large extent, be best understood in terms of the impact on the decision maker of taking certain decisions. For example, for managers, pressure might come from within the organisation if targets were not met, or for practitioners, the time implications of taking longer than was necessary on a piece of work.

Despite the justified emphasis placed on pragmatic practices in this Chapter, matters of organisational esteem or professional self-concept should not be regarded as wholly irrelevant considerations. There were several hints that these were important for both managers and practitioners, although professional social work considerations generally existed more in the background rather than the foreground of decision-making. The 'foreground' of managerial decision making seemed to be largely influenced by 'throughput', as managers throughout the organisation were mainly judged on how well they met performance measures. Managers who were directly responsible for allocating work and supervising practice faced the most tangible negative impact in terms of loss of organisational esteem if targets were not met, especially, as league tables were circulated around the organisation which compared the relative performances of different teams. As a consequence, both managers and practitioners appeared to be very mindful of the time implications of

any decisions they made. Options that were potentially time-consuming; whether this be in respect of more time spent with the older person; time spent following up issues or recording what had gone on in any great detail, were generally avoided. From observing and interviewing participants, the overriding impression gained of the care home review system was that they felt strong pressure to ensure that they got through the work as expediently as possible. Consequently, although this appeared to trouble the 'professional' consciences of some more than others, that was the overarching principle that guided their exercise of discretion.

The framework for discussion in this section has mainly been derived from the critique of Lipsky provided by Evans which, while it has accepted many of Lipsky's underpinning ideas about discretion and its use at the front line, has broadened the scope of enquiry to include the role of managers. Evans' critique has also highlighted the impact that a sense of professionalism might have on the use of discretion by both managers and practitioners. In discussing this he recognises that in developing the debate beyond 'street-level bureaucracy' as originally conceived by Lipsky, several key areas for further research are indicated, which are:

The ***organisational context*** of discretion; the ***orientation and concerns of management***; the ***nature and effectiveness of management control of practice***; and ***the nature of the relationship between street-level practitioners and their managers*** (2010a: 65). [My bold and italics]

It is these factors that I now turn to in relation to the statutory care home review process.



## **Examining managerial and practitioner pragmatism**

I have talked about the predominantly pragmatic way in which managers and practitioners took decisions around reviews and in this research I can utilise Evans' headings quoted above to examine the various factors that shaped the character of this pragmatism.

### ***Organisational context***

The organisational context was shaped by various national and local factors. Firstly, as explained in Chapter Five, the organisation had had to absorb a succession of major policy initiatives with, perhaps the most destabilising being the integration of health and social care instigated by New Labour's 'modernisation' agenda (Department of Health, 1998). The effect of this was to create uncertainty about structures, roles and responsibilities. However, the 'rolling out' of significant agendas such as 'personalisation', 'mental capacity' and 'safeguarding' had also meant that new, potentially contradictory, ways of working needed to be understood and adopted. New Labour's modernisation agenda from 1997 onwards had also helped create an underpinning performance culture through, amongst other measures, the introduction of a large number of performance indicators and star ratings for local authorities. In addition, in this case, an inspection by the local regulator had demanded improvement. In broad terms, the effects of these combined factors meant that the organisation was unsure of itself, inward looking and defensive. It needed to demonstrate competence by meeting mainly quantitative targets.

### ***The orientation and concerns of management***

Related to the factors highlighted above, it was apparent that because of the various restructurings, there was a significant degree of managerial turnover. For many managers, having to apply for, hold on to their job or learn a new job role was a major concern. The integration agenda also meant that NHS managers found themselves managing social care staff and *vice versa*. In this context, managers were having to make sense of and implement a range of policy agendas and were uncertain about where exactly to direct their efforts. However, amongst this uncertainty meeting targets appeared to be a tangible means by which they could demonstrate their effectiveness as managers in the organisation. This meant that a pragmatic approach offered some security.

### ***The nature and effectiveness of management control of practice***

The number of reviews that took place could be monitored by management through electronic systems. However, the only routine checks on the quality of practice were through supervision and reading review records. Supervision was more managerial in character than professional. That is to say that the main focus was on how much work the practitioner was getting through rather than a discussion of professional practice or quality issues. However, according to the senior social worker, when discussion of professional practice issues did take place, she was not always confident that practitioners understood or gave sufficient thought to what they were doing. Poor recording also appeared to be widespread, case records were mainly checked by managers, quite literally, for boxes ticked rather than the quality of case recording.

ICT continued to be a pressure factor for front-line practitioners in line with the findings highlighted by amongst others, Bovens and Zouridis (2002) and Postle (2001; 2002) in Chapter Three. However, whilst the ICT systems used in the County meant that managers could allocate work electronically and also discover electronically at what stage of completion the review was, they had little or no direct control over standards of practice. Practitioners had little discretion about how many reviews were allocated to them each week, although they did have significant discretion in *how* reviews were completed. This contributed towards a work context where quantity rather than quality was what mattered.

### ***The nature of the relationship between street-level practitioners and their managers***

Care managers generally felt pressure from management. There was a feeling expressed that they could not be expected to do a good job if their case load was too high. Care managers recognised that standards of practice were compromised by various factors. The most important of these appeared to be lack of time, but a lack of specific knowledge or training in certain areas was also mentioned as contributory factors. It was difficult to discern how exactly care managers' practice would change if their workloads were to be cut. Care managers were under pressure to resolve the dilemmas of balancing quantity and quality with little management support. However, despite this, there was little overt antagonism towards specific managers it was more a non-specific resentment of systemic pressure. Care managers often referred to a non-specific 'they', for example:

They're now coming on with all this pressure to do all this amount of reviews in a week which would have, the standard would have to be lowered to get them done (CM1).

Line managers also felt the systemic pressure. They were aware of the need to compromise standards and the extent to which they were prepared to tolerate substandard practice varied. Both the locality team manager and the senior social worker talked about having to 'pull people up' from time to time when practice became obviously substandard. The senior social worker did this more frequently and, seemingly, with more emotional investment. The nature of the relationship between managers and practitioners was certainly not one of mutual professional respect. However, neither was it one of complete mutual mistrust. In the main, street-level practitioners and their managers seem to strike a pragmatic settlement whereby in order to get through the work without creating too much extra pressure for each other, they broadly tolerated each other's positions.

Applying Evans' headings to this case has brought into sharper focus the character of the pragmatism that guided how managers and practitioners exercised their discretion. Pressure to complete work probably meant that, on the whole, managers or practitioners colluded with each other not to seek out issues or take decisions that would add significantly to either their own or each other's workloads. This was evident in the reviews observed; and is also evident in reports from the locality team manager and senior social worker. This was no better encapsulated than in the locality team manager's reply to my observation that case recording was minimal:

LTM: Why do I need to capture every word of somebody's conversation? What does it add to anything?

I: Well, it might well be...

LTM: If you think that I have to balance quality and quantity. If we have to meet performance indicators, if we have to keep things moving along and we have to manage people's time.

Whilst using Evans' list of potential areas for research factors has proved helpful in understanding how and why discretion was exercised by managers and practitioners to pragmatic ends in this case study, there are certain key areas missing from that list. Evidence exists that care managers, in certain circumstances, can and do resist managerial discipline and go creatively beyond the procedures (White, 2009). However, the findings in this case indicate that care managers either did no more than follow procedures unimaginatively or, at times, failed to follow the procedures fully. Although, not overtly detectable from the interviews, this type of practice seen in statutory reviews suggests that the fact that they were reviews of care home placements for older people might be a significant factor. It could have been that, on some level, practitioners, because the older people were relatively 'safe' and their basic needs met, this category of service user warranted less time and attention than others in the community at risk of losing their independence. This is clearly speculative, but, nevertheless, suggests that Evans list of areas is, perhaps, too focused on the character of and dynamics within statutory organisations and does not sufficiently take into account the orientation of managers and practitioners towards the situation of particular service-user groups about whom decisions they are making decisions.

## **Non-statutory participants**

The contingent, pragmatic and, at times, *ad hoc* character of the way statutory participants exercised their discretion in approaching care home reviews created varying degrees of confusion and frustration for non-statutory participants. However, the uncertainty around the purpose of reviews and review practices also created more discretionary space for non-statutory participants to shape the process, content and outcome of reviews. Apart from the service user, there were two broad categories of non-statutory review participant: service providers (private and voluntarily run care homes) and relatives. Evans expands the scope of Lipsky beyond front-line practitioners, to focus on the discretionary role played by statutory managers. As it was not his primary focus, Evans is largely silent on the discretionary roles played by others in the social care system. Adult social care has been reconstructed and continues to be being transformed in the UK around the notions of the efficacy of markets, voluntarism and privatisation of care as indicated in Chapter Two. Therefore, this case study suggests that the roles played by different non-statutory actors in implementing policy should be included in further research. If, as Evans suggests, we need to go beyond street-level bureaucracy in understanding how the exercise of discretion impacts on service users, then this needs to take much fuller account of the increasingly dispersed nature of discretion and, perhaps, more importantly, the organisational, managerial, professional and also personal factors that guide how discretion is exercised.

### **Care providers**

The field work revealed that managers of care homes did not like to have people placed with them whose needs they felt they could not meet. Specific examples were

found where an older person had complex needs or challenging behaviour. On such occasions, care home managers might use reviews to request that a resident be transferred. This applied to both care homes and care homes with nursing.

Admissions to care homes following a hospital discharge appeared to be a common source of such concerns. For example, one care home manager (CHM1) told me about a woman who had been admitted:

....when she came in here, still no reviews, so we actually, because we've got a few concerns about the placement, I actually contacted the call centre, and said, I'd like to request a review for this lady

In such circumstances, reviews become very consequential, not only for the older person whose place of residence might be under threat, but also the care home and the local authority because of the cost, time and workload implications. Whilst, quite reasonably, care home managers indicated that such requests were inspired by the desire for the older person to be appropriately placed, there was no way of telling, in a commodified care market, how much any such decision was inspired by the fact that the resident was costing too much in terms of the fee the home was receiving and also by blocking a bed that could be given to a resident who was more easier to manage and represented better value for money. Whilst financial costs might well be a factor in a care home manager's decision to call reviews, it would be oversimplifying the matter to infer that such decisions were motivated by commercial factors alone. For example, the Elms, where OP3 was placed, was run by a private company. However, from an initial review, the manager worked quite creatively with the local authority to ensure that, despite not being a registered home for

dementia, OP3 (who had dementia) remained at the home. This required getting special registration from the regulator and securing a higher rate of fee from the local authority. It helped OP3 that her relatives were very vocal in supporting this course of action. In the context of dispersed discretion, it is not impossible to imagine that a different care home manager, in circumstances where there was no relative involvement, could have requested that the older person be moved. In any event, the older person's fate, on such occasions, always appeared to be mainly at the mercy of others' discretionary actions.

### ***Relatives***

It was highlighted in Chapter Two that both the issues faced and roles played by relatives of older people admitted to care homes has, more recently, become the focus of research (see Edge, 2008 for an overview). This study bears out the findings of that research in that there is no 'universal' relative perspective. It would also be simplistic to attribute a set of common feelings or motivations to the relatives of care home residents, be this guilt, regret, relief or any other emotion. However, relatives' feelings and motivations emerge from a complex set of interacting factors, such as the character and quality of previous relationships, the pre-admission circumstances and several other factors. Therefore, whilst the contribution made by relatives in reviews is contingent on many factors, the study illustrated that, if so minded and sufficiently informed, relatives were able to play an important part in initiating actions and also in shaping decisions taken by the other key participants in respect of their relative. Therefore, the effects of the discretion exercised by relatives in and around care home reviews are not inconsiderable. It has also been shown, for example, that the possibility exists for relatives and care home to form alliances in



opposition to a care manager's preferred course of action or for a care manager and relative to align (at least on the level of talk if not necessarily effective action) against a care home's practice. Therefore, the overall contribution that can be made by non-statutory participants in reviews is highly significant, although how it operates is complex and contingent on many factors.

## **Older people**

Notwithstanding the stated objective to gather multiple perspectives on the review system, the question underlying this discussion, and indeed, the whole thesis, is where this leaves the older person? As indicated previously, in Lipsky (1980) and most of the subsequent studies of Social Services that have used Lipsky as their starting point, the service-user's perspective is missing. However, as those studies have shown (particularly Evans, 2010a) neither managers nor practitioners can be regarded as homogeneous groups and, so it is, with older people in reviews.

In Chapters Five and Six I explained how there are different types of statutory reviews which take place in different circumstances and can serve different purposes. As explained in Chapter Two older people in care homes are not a homogeneous group, they vary greatly in many respects, including their mental capacity, their family circumstances and their attitudes to living in a care home. As also explained, there are different types of care home. Therefore, it is impossible to generalise the older person's review experience. However, as proposed in Chapter Seven, my observations of the reviews in the County lead to the conclusion that the older people ended up either adopting or being steered in to a position of 'passive participation'. It was explained that this was possible through the exercise of

discretion by other review stakeholders in pursuit of their own, mainly, pragmatic agendas. The less active the older person in taking control of the agenda and raising issues of their own, the less likely the professionals involved around them would feel the tensions associated with taking the extra time to problem solve and deal with any issues properly.

In Chapter Three I highlighted how 'service user involvement' has become an organising principle – almost a mantra - for those working in all aspects of public services. Whilst 'involvement' can have several meanings and take many forms, I explained how statutory reviews could best be understood as a consultation exercise within the consumerist paradigm of service-user involvement. I cited Barnes and Kendall (2001) whose observations about consultations are pertinent here. Based on their research involving disabled people, they argue that:

Consultation can itself become part of the oppression of disabled people through the methods it adopts, and through findings which may continue to silence or misrepresent their experience (Oliver, 1992). To ensure against this, an open-ended, exploratory and flexible approach can be adopted which employs non-hierarchical research relationships, but this might well lead to findings which are concerned with much broader issues than those defined by the funders, and which the contractors have little power to address (Shakespeare, 1996).

In practice, the participants of a consultation exercise can rarely set the boundaries. These have usually already been set by the funders/commissioners. At a minimum, contracts will usually specify time and resource limits and a pre-defined agenda. Therefore, from the outset, researchers can be caught between competing demands (Lloyd *et al.*, 1996). (Barnes and Kendall, 2001: 17).

It was worth quoting at length because of the striking parallels between what Barnes and Kendall say about the relationship between disabled people and researchers and the relationship between care managers and care home residents in statutory care home reviews. From the empirical evidence, statutory care home reviews can certainly be a source of potential oppression for older people. Oppressive practices observed took many forms, ranging from the older person:

- being required to take part in an exercise that is not fully explained and not fully understood;
- to being talked over or talked about while present;
- to being asked to give views and opinions in good faith but having no actions taken or feedback given as a consequence;
- to having the most private and intimate parts of their life exposed and discussed, often with strangers;
- to having oneself constructed in ways that de-individualise in case records, and
- to being brought in to attend a meeting not because of any interest in obtaining a better understanding of your life in the care home, but as a means of legitimating the process<sup>25</sup>.

Arguably, oppressive practice most commonly takes place any time when the older person has no control over the process or outcome of the review and where their rights to privacy, dignity and choice are denied.

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<sup>25</sup> In many respects the findings echoed those found in research by Corby *et al* (1996) who studied parental 'participation' in child protection conferences. The overall effect of 'participating' in a consensus producing process where their (potentially conflicting) views were not actively sought contributed to parents' disempowerment rather than empowerment.

Reviews should not be regarded simply as a source of potential oppression for the individual older people involved. All care home residents are potentially oppressed by a system which allows, for example, for a number of individual reviews to take place in a home where substandard levels of care exist and where no comment about poor care standards is made as a consequence. Here I am referring to the situation described to me by the locality team manager (Chapter Five). Statutory reviews without issues raised, concerns recorded or actions taken, imply that a care home's standards are acceptable when this might be not justified. Reviews carried out in those circumstances, should have fed in to the wider system of regulation and contracts monitoring. Yet, little liaison between these various systems appeared to take place in the County. It is hard to know how far that lack of communication can be generalised. However, in a system of adult social care that has become much more fragmented in recent years and with accountability increasingly dispersed and blurred as a result, arguably, the potential for poor communication between the various parts of the broader regulatory stem is increased; and that certainly appeared to be the case in the County.

The nature of much of the oppression encountered in the review system was not wilful, it was inadvertent, almost casual, often the unintended consequence of trying to do the right thing by the older person but without thinking through fully the consequences of their actions. For example, when the care manager brought an older person who lacked mental capacity into the group discussion or asked questions about their life in the care home, their failure to orientate them fully led to

confusion and discomfort. However, the persistent disregarding of older people's rights in care homes, for whatever reason, should be regarded as a form of ageism (Lymbery, 2005, pp. 13-15) and may well be a fundamental reason why many of the care manager practices observed tended to be guided more by the desire to save time rather than explore issues in more depth. In Chapter Two, I highlighted how in 2001 publication of the NSF for Older People had, as its first standard the 'rooting out age discrimination' (Department of Health, 2001b). A national follow up study by the Commission for Social Care Inspection has described progress toward this goal in care homes as a 'mixed picture' (CSCI, 2006: 47). The report states for example:

Despite these changes there is still evidence of ageism across all services. This ranges from patronising and thoughtless treatment from staff, to the failure of some mainstream public services such as transport, to take the needs and aspirations of older people seriously. Many older people find it difficult to challenge ageist attitudes and their reluctance to complain can often mean that nothing changes (*ibid*, p.7)

The study of care home review practices in the County would suggest that the way statutory reviews are carried out in care homes for older people remains an area where further progress on ageist practices needs to be made.

Flagging up the potential for oppression is important. However, the findings from this study do not mean that every review carried out is oppressive or that, even if certain aspects of reviews are oppressive, the benefits to older people of having their care placement reviewed might outweigh the oppressive elements. Arguably, in the

course of their lives, most older care home residents will have encountered many more onerous or oppressive events than reviews and will have the resilience to cope with being subject to a care review once or twice a year. However, in a context where older people funded by the local authority have no choice over whether a review takes place; where the discretion to shape all aspects of the review process is dispersed amongst multiple stakeholders, often with potentially different review agendas; where official review goals are ambiguous and where resources, including time, are short, as Barnes and Kendall (2001) make clear, the potential for oppression is inherent in the review system and that should be acknowledged.

This raises the question of what, realistically can be done to make statutory reviews work better from the older person's perspective? In reflecting on this challenge, a distinction needs to be made between seeing reviews from the perspective of the individual and seeing reviews in a more general sense as part of the wider system of care home audit and regulation.

Taken collectively, statutory care home reviews could be said to provide an important and useful regulatory function in that, in general terms, they help to keep a check on care home standards and help the local authority to ensure that value for money is provided. It is also arguable that care home residents are better safeguarded by any system where outside professionals are required to visit a care home to review its care provision. However, two important caveats need to be made in respect of these claims. The first is that reviewers need to know what they are looking for and that information from reviews needs to be recorded and properly fed back into the wider

system of care home regulation, which it currently appears not to be if the situation in the County is any measure to go by.

The second *caveat* concerns self-funders in care homes. This research has specifically focused on statutory care home reviews for those in receipt of local authority funding. However, the circumstances of funded and self-funded residents are intertwined. As explained in Chapter Two, although it is hard to ascertain precise figures, the proportion of self-funding residents in care homes is rising (SCIE, 2011). It is also thought that the number of older people that start off initially funding their own care in care homes but run out of money and then seek council funding is also rising (SCIE, 2011). Therefore, in that sense, self-funders and funded residents are not necessarily separate groups of people. However, it is also claimed that in many homes, the higher fees paid by self-funded residents subsidise local authority funded residents, so there is also a financial interrelationship between funded and self-funded residents. If part of a statutory review's function is to determine whether the local authority is receiving value for money for its funded residents, then, arguably, this should also apply to self-funding residents, who might well be paying more for their care. However, self-funders do not currently have the right to this type of review. This group of care home residents would, therefore, only derive any indirect benefit from the system in care homes where local authorities fund some of the residents and where action over quality issues was undertaken. However, some care homes have no local authority funded residents. Apart from the Care Quality Commission, which, as discussed in earlier chapters, has been criticised for its failures to safeguard the interests of older care home resident properly (see also, Parliament,

2012), no other statutory body protects the concerns of vulnerable older people in care homes when they self-fund.

From the perspective of the individual, the statutory review system appeared to be of little value to the small number of care home residents encountered in this study. However, despite the lack of direct evidence found from the interviews and observations, it is possible to imagine why statutory reviews might have potential benefits for individual older people in care homes (Scourfield, 2007c). Without wanting to homogenise the whole care home population, for a section of society that, for various reasons, could be considered 'vulnerable', and who are at greater risk of social isolation and abuse because of their circumstances, reviews present an opportunity for an external check on an older care home resident's quality of life and a rare opportunity to express their views about matters that are important to them.

The evidence from this study indicates that reviews could be improved in several key areas. These would include;

- improving communication and information sharing between all parties on admissions to care homes from hospital;
- ensuring continuity of care manager across an older person's time in the care system would help personalise the review system and help with the establishing trust and orientating the older person;
- providing specific training for care managers on what constitutes good standard of care in care homes; and,



- providing care managers with proper training in how to communicate with people with cognitive impairments of all kinds, especially given the difficulties seen with OP2 and OP3, both of whom had dementia and appeared to experience varying degrees of discomfort and disorientation in their reviews.
- ensuring that concerns about care that emerge from reviews are routinely fed back into the wider regulatory system.

However, this study has also drawn attention to the dispersal of power, the blurring of accountability and the various factors embedded in the system that pressure those within it to be pragmatic, to accept compromises in practice and to tolerate sub-optimal standards of care. As indicated earlier, in many ways this study has replicated the findings of Postle (2001; 2002) in terms of what it has revealed about the tensions associated with putting care management into practice and about the reasons for such tensions existing. In 2002, Postle concluded that:

Social work's traditional position of tension and ambiguity appears to have been exacerbated by recent changes. These tensions need to be addressed because of their detrimental implications for care managers' work. It seems likely that a deskilled and demoralized workforce perceiving itself to be operating a reductionist process of assessment in a climate where managerialist and financial concerns predominate will give poor quality service to the older people with whom it works (p.347).

Ten years later, it is clear that, despite the introduction of several new policy initiatives in adult social care, the fundamental problems facing care managers are

the same, if not worse. Therefore, it would be naive to lay down a list of prescriptions and not to expect them to become open to compromise for the reasons rehearsed throughout these chapters. Neither of the two key stakeholders in care home reviews - locality authority care managers and care home managers – is well placed to be responsible for effectively reviewing an older person's care home placement. With both being part of a wider care home review system whose concerns include managing resources, the 'delivery' of care on low fees and generally keeping a lid on costs, it is, in effect, asking the system to review itself. However, as will be discussed further in Chapter Nine, this is a system that is largely, uncomfortably, aware of its own mediocrity and, despite the good practices and stated good intentions of many who work in it, to acknowledge the full extent of its mediocrity would be to intensify the tensions experienced by those working in the adult social care system, with very little prospect of resolving them.

To conclude, this Chapter has used the findings from the study to engage in critical dialogue with others who have sought to apply Lipsky to social services in the UK. I have generally supported the findings of those such as Postle (2001; 2002) who found that the bureaucratised and proceduralised version of care management that prevails in many local authorities is a flawed means by which to ensure that vulnerable older people receive satisfactory care arrangements, especially, as Postle and others have also concluded, when care management takes place within a context of organisational change and ambiguous policy goals. I have also suggested that there might be an undercurrent of ageism in the way that older people's care home reviews appear to have so little time given to them.

Using Evans (2010a, 2010b) as a reference point, I have underlined the importance of managerial as well practitioner discretion in shaping the review system. However, I have shown that the statutory review operates within a system of mainly independent care homes operating in a market and this has required the discretionary actions of care providers to be included in the analysis. I have therefore argued that the exercise of discretion in statutory care home reviews is more appropriately conceptualised as being multi-layered and dispersed amongst multiple state and non-state actors. Ultimately, I have concluded that care home reviews, as they were observed, offer little opportunity for the genuine empowerment of older people in care homes; instead, I have argued that, at their worst, they are a source of an additional oppression for older people. On a positive note, they can be used to effect certain changes for the older person. However, the most significant changes as a consequence of reviews, such as change of home or additional resources, are more likely to occur at the behest of others. Changes requested by older people themselves are likely to be comparatively minor. Care home residents are the least powerful actors in reviews. Arguably, the participation of relatives offers the best chance of empowering older people; however, it cannot be assumed that this will always be the case. Relatives' interests need not be congruent with those of the older person and even well-intentioned relatives are capable of manipulating the older person if they believe they 'know best'. It is also possible that other participants can exercise their discretion to 'neutralise' a relative's advocacy if it believed that they, and not the relatives, know the older person best. Independent advocacy might offer a possible solution (Scourfield, 2007b). However, this proposal is not without its difficulties. Not only is the availability of appropriate advocacy scarce, its provision

would add to costs and the question of who should pay would become another complicating factor – not least in how ‘independent’ it was. However, advocates would also add to the multiplication of actors in an already fragmented sector where accountabilities are already blurred. Therefore, however desirable independent advocacy might be in certain cases, this cannot realistically be offered as a blanket solution.

Whilst the empirical work and subsequent discussion has provided a certain amount of evidence to answer the main research question, it has also raised several questions that might form the basis for further research. Assuming that statutory care home reviews continue to take place, most important, is how to develop procedures and practices that offer older people more genuine control over the process and reduce the chance for oppression.

Finally, in Chapter Four, I highlighted the difficulties I experienced gaining field access. Treating this process as additional data for analysis provided additional insights into how the system of older people’s care operated in the County and provided further evidence of the dispersed and multi-layered exercise of discretion by those within it. Therefore, before drawing the thesis to its final conclusion, Chapter Nine provides a critical discussion of key issues emerging from this important part of the research process.

# Chapter Nine: Encountering street-level bureaucracy at first hand

## Introduction

In Chapter Four, I explained that, after conducting the pilot study, the collection of further data was significantly held up because negotiating further field access both to observe reviews and to interview participants took longer than anticipated. This also yielded fewer willing participants than originally desired. As this protracted process of negotiation dragged on, it became evident that it required analysis in its own right because, as Wolff, 2004 states:

A preoccupation with the way into the field serves not only methodological or research-pragmatic purposes, it also yields insights into structures and sequences in the research as a social event, and into the field of action that is under investigation. The trial paths, detours and false trails that researchers often complain about and feel to be burdensome, and even the failed attempts at gaining access - which are normally carefully suppressed all then become 'critical events', the analysis of which opens up chances of making discoveries (p. 198).

In this case, I made three specific 'discoveries' about the field that helped better answer the questions of both *how* and *why* discretion was exercised by 'insiders' in response to 'outsiders' (i.e. myself) requesting access. In other words, the experience gave me a flavour of what it is like to encounter street-level bureaucracy at first hand. The *first* 'discovery' from the process of field access negotiations was how, from the outside, the system of adult social care in the County was hard to

understand in terms of establishing organisational roles, responsibilities and structures; a situation exacerbated by continual reorganisation and restructuring. Not only was identifying and finding the contact details of gatekeepers like trying to hit a moving target, but once identified, the gatekeepers were often unable to make appropriate decisions because, if new in post, they were unsure of their roles and responsibilities. The *second* 'discovery' from negotiating access was that it provided first-hand experience of the defensive mindedness that characterised many of the County's street-level bureaucrats that I encountered and ways in which this mindset appeared to inform the repertoire of discretionary strategies available to them. Such strategies were effective because they were seldom plain refusals. As a consequence, they effectively disabled any research activity from taking place in ways that were harder to challenge. The *third* 'discovery' in the field was about learning that the exercise of discretion was widely dispersed both horizontally and vertically in each organisation researched. Alongside conventional street-level bureaucrats and their managers, others played important discretionary roles at the front line in shaping the experience of 'outsiders'. Adopting a term used by Lipsky (1980), I refer to these others as 'screeners' where:

The role of screener would not be cause for comment if screeners performed their jobs as they are defined in theory-that is, making decisions involving minimal discretion. However, in important respects screeners often come to function as street-level bureaucrats, exercising discretion in important areas of people's lives, although without the authority to do so (p. 129).

What follows is a critical account of the process of negotiating field access in which each of the 'discoveries' described above will be discussed in more detail. To

evidence the discussion, additional data from the negotiation process (mainly email correspondence) is used to provide further insights into the dispersed nature of the discretion exercised within the statutory care home system in the County and the, predominantly, defensive attitudes of those I encountered who work that system.

## **Gatekeepers and organisational change**

It is generally recognised that organisations can present complex challenges for researchers (Bryman, 1988; Lewis (2003). (p. 62). Morrill *et al.* (1998) make the point that, for various reasons, negotiating access is made all the more difficult at times of organisational restructuring. For example:

Identifying and managing gatekeepers in organizations undergoing radical change presents practical challenges because local, legitimated accounts for authority and decision-making can change rapidly, thus invalidating the information gathered about the organization at any one time (p.69).

In this case, field access was not only complicated by the fact that organisational structures underwent significant changes during the research process as explained in Chapter Two, but also, to achieve its goals fully, the study required, at various points, the participation of staff who worked in at least three different organisations; the local authority, the local Primary care Trust (PCT), and both private and voluntarily run care homes. I discovered that gaining ethical approval did not guarantee satisfactory field access. An additional complicating factor was that the study also required the participation of older residents of care homes, whose status conferred a *de facto* vulnerability (Department of Health, 2000). It was practically

impossible to find out the names and details of care home residents who had either recently had a statutory care review or were due to have one, without the assistance of gatekeepers in one of two key organisations. These were managers of locality teams (the teams being responsible for actually carrying out reviews) and care home managers.

Locality team managers were the principal gatekeepers when I was seeking to observe reviews. However, even obtaining details of the teams and their managers proved difficult. As part of the implementation of the 'modernisation agenda' referred to in Chapter Two, the County had set up a 'contact centre'<sup>26</sup> as the only 'portal' through which the outside world could access the system (see Coleman, 2009 for a discussion of this relatively new phenomenon in Social Services). Therefore, to prevent direct contact, team details were no longer available to the public. When the contact centre was approached, the ethical approval obtained through the County's research governance procedures meant nothing. The contact centre call handler (a 'screener' in Lipskyean terms) informed me that they needed to consult with their manager and get back to me. In fact, it took three further calls and a fax to successfully establish my '*bona fides*' over a period of six weeks. With persistence, it was possible to obtain the required information. However, the experience with the contact centre provided an interesting insight into how people outside the system are processed. In Lipskyean terms, the call centre played a 'people processing' role, filtering 'contacts' into pre-structured categories. The inability to process a 'non-standard' contact revealed the limitations of a system supposedly designed to

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<sup>26</sup> The County Council's Contact Centre took over all contacts about and referrals for adult social care in May 2003



improve access to services. However, having eventually obtained details of the teams, the eight locality teams' managers were emailed with information about the project, together with a request/offer to visit their team to provide more information and answer any questions. If there was no initial response, (and, generally, there was not) a minimum of one follow up email and one phone call was made in each case, often more. It was not uncommon for several weeks to elapse during this process.

Trying to establish contact with locality team managers was definitely made more difficult because many of them were in the process of being relocated or changing roles as a consequence of the various restructuring exercises also referred to in Chapter Two. For example, following one reorganisation where locality teams in the County had been reconstituted under new management structures, one of the new team managers responded to a follow up email:

At this moment I don't feel that the team are in a position to assist with this. Sorry

Emailing another manager who, earlier, had looked a promising contact, I was told:

I am still in post but now I am an area manager covering the whole of XXXX and XXXX. I have copied the new team managers into this email to enable you to have their email contacts.

Therefore, not only was the identification of managerial gatekeepers difficult, the access negotiations involved repeating the same information to gatekeepers, often

new in post and, evidently, more concerned with other priorities. Not all managers proved elusive or unhelpful. One locality team manager invited me to a team meeting in order to explain the research and make my request for volunteers amongst the care managers. I gave a 10 minute presentation after which I took questions and distributed an information sheet with my contact details should care managers wish to participate. No one volunteered, and after about three weeks I contacted the team manager to express my disappointment. As a result she 'volunteered' a care manager who mainly worked on reviews. It became fairly clear that the care manager would not have agreed to participate had it not been for her manager's intervention. The nominated care manager ostensibly took an interest in helping me but she always took a long time to reply to my emails and phone calls and, despite lengthy negotiations which involved her deliberating about what reviews might be suitable, she never managed to find anything 'appropriate'. After about three months of this process I was informed by her office manager that she had gone on long-term sick leave.

In another team, the manager also nominated a care manager to observe. This was a new member of staff. It transpired that she did not want to participate because she was new and not confident about her practice being observed. I thought this was an understandable response and when I fed this back to the manager, she 'volunteered' another, more experienced, member of her team. Although I came with her manager's endorsement and I informed her that I had all the necessary permissions, the initial response from this care manager was to ask me several checking questions, including whether I was police checked and whether a senior manager in her organisation had given his permission. I was able to provide satisfactory answers

to each of these questions and, given her tone in responses to my reminders, I was reasonably optimistic about a positive outcome. For example, in response, to a request to meet up to discuss progress in finding a review to observe, she replied:

I have not forgot about the reviews now have you the paper sorted out just need to make some appointments....

'The paper' referred to a request to see a copy of the County Research Group's permission which I had sent to her. Despite my belief that I was dealing with all possible obstructions, negotiations with this care manager continued for approximately a year and, although she never refused to co-operate nor requested to withdraw, she was not able to identify an appropriate review for me to observe during the twelve month period spanning 2008/2009. Again, this 'negotiation' was characterised by lengthy delays in responding to my reminders. Even though I had not provided her with any criteria for selection other than requesting to observe a statutory care review, the care manager conveyed a sense of wanting a specific type of review for me to observe. Whatever her exact criteria (which were never articulated) were for selection, it appeared that the right 'opportunity' never arose throughout the period of time I was in contact with her.

Overall, the negotiations that followed the pilot stage yielded only one more review observation. These events underlined the point that even when official gatekeeper approval is obtained, practitioner compliance is not guaranteed. Reluctant to openly refuse, practitioners apparently found ways of subverting managerial direction.

These episodes provided interesting cameos of street-level bureaucracy in the way

practitioners were able to exercise their discretion to adapt managerial demands to produce their desired outcomes. The overall effect, whilst demoralising, provided me with evidence of how, through the exercise of discretion, outsiders to the system could be rendered inactive.

As explained in Chapter Four, to augment the observation data, I decided to interview older care home residents whose placements had recently been reviewed to elicit their views about their experiences. At this point, care home managers became the main gatekeepers. Firstly, I returned to the three homes where reviews had been observed on the basis that there was a pre-existing research relationship. A significant degree of managerial turnover was evident here. Of the three homes where reviews were observed, two of the managers had left their post by the time I made my follow up request which, in each case, was less than six months afterwards. On closer examination, it appeared that this rapid turnover of manager reflected a national trend in care homes (Community Care, 2010). This strategy therefore yielded only one resident interview – from the one home where the manager was still in post.

My second strategy was to use a contact within the Care Quality Commission (CQC) to identify local care home managers who she believed would most likely respond to my research request. She identified three managers whom I contacted by telephone. I made a point of informing them that I had been given their name by the CQC inspector, hoping that this would deter them from ignoring my request. All three of them responded positively and invited me to visit and provide further information.

However, this strategy yielded only one further resident interview. It is unclear why this route was not as successful as I had hoped. I was not completely ignored and there were signs that some efforts were being made. For example, one of the managers, initially, showed quite a high level of interest in the research but, despite reminders, claimed that she was not able to identify any suitable participants over the six month period that followed. Follow up emails initially received a response. For example, the following was received after three months:

I have had a few reviews but they were Dementia residents (sic), when do you have to complete your work? Don't give up hope I will keep trying for you.

The tone is helpful and, as we had discussed that I was only interested in interviewing residents who had mental capacity, a very plausible reason is given. However, several weeks went by without further contact, phone messages were left but not answered, email reminders drew responses of increasing brevity about being away and the final reminder, six months after the initial meeting, received no reply. In many ways there were parallels with my negotiations with the care manager who was never able to identify the appropriate review to observe. Although I was not able to explore their motivations behind what I saw as a form of 'procrastination', on reflection, I wondered whether rather than simply wanting to delay or obstruct me, these volunteers were hoping to find the 'ideal type' of subject where everything (including their practice) would be seen in a positive light.

The tactic of using the CQC inspector was successful in that each manager replied very quickly and expressed interest in helping. Arguably, given their relationship with

the nominator, they were unable to refuse or not reply. However, having initially been positive and cooperative, all three cases gradually disengaged for reasons that I was unable to understand. At the time I reflected that had it been a piece of official CQC sponsored research rather than an individual student's PhD – which became clear once I provided the care home managers with details – the outcomes might well have been different. This illustrates that a powerful sponsor can facilitate access but they cannot guarantee cooperation (Wanat, 2008).

Finally, I 'cold called' other care homes in the vicinity. No resident interviews were negotiated through this route. Managers either ignored requests or said they would get back to me but then, despite reminders, did not. In all, eight care homes were approached out of a possible fourteen in the immediate locality. Of the six *not* approached, three were run by a large private chain. The CQC inspector had already given me introductions to two managers of care homes run by this chain. However, she advised against my approaching certain other homes run by the chain because they were in difficulties of various kinds. A further three that I decided not to approach were relatively expensive<sup>27</sup> private homes that I was advised would have few, if any, local authority funded residents. As a general rule, initial enquiries were carried out by telephone. As long as the care home did not explicitly refuse, if nothing further was heard, the initial request was followed up with, at least, three more telephone or email reminders. I very seldom found the care home manager 'in' and care home office staff would either ask me to ring again or take my details.

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<sup>27</sup> For example, charging at least £500 per week when the local authority 'benchmark'/baseline figure was £395.

These encounters provided more evidence of informal 'screening' which will be discussed more fully later.

One particular encounter with a private care home is worth recounting in some detail because it provides insights into the blurred lines of accountability that can exist in the independent care home sector. Having checked the care home's details on the CQC website, I telephoned and asked for the manager by name. The man who answered the phone informed me that the manager was not there and asked what I wanted. When I explained the purpose of the call, he then said that he was actually the regional manager of the private care home company that ran the home. He appeared to be positive about my research questions and explained how, in his opinion, statutory reviews were useful for staff, relatives and the older person. Encouraged, I returned to the issue of how to gain access to residents to seek their views and he suggested I put a request in writing to him at the regional office and that he would get back within a week. I sent the request later that day, supported by participant information and confirmation of ethical approval. A week later, having heard nothing, I rang the regional office to be told by someone in the office that the regional manager was effectively 'firefighting', very seldom visited the office, had not been in for at least a week and was not scheduled to visit again for another week. My unopened letter - sent first class - was duly located and put to the top of the pile. The person at the regional office suggested that the best way to contact the regional manager was via his work mobile. I rang and left a message which remained unanswered. After some days, I rang the care home again hoping that the manager would have returned. The receptionist informed me that the actual manager whose details were on the CQC website had left some time ago and the regional manager

was in temporary charge of the home – something he had failed to tell me in the original call when he implied he just happened to be there on a visit. I left another message for him to call but he never replied.

It is interesting to note the regional manager's unwillingness to admit that the home was managerless which seemed to be a major factor in not making any progress. The organisation was experiencing serious problems of management and the reluctance to allow a researcher in could be understood in this context. However, the regional manager seemingly wanted to obscure the reality of what was going on. The suggestion to put the request in writing was followed by a string of unanswered messages. It would appear that when 'caught cold', there was unwillingness to actually say 'no', but that, given time to reflect, the gatekeeper's instincts were to impede access to the system. Ironically, this exchange took place in the same week that CQC revealed the full extent of managerless care homes (Community Care, 2010). My experiences provided further evidence of the apparent chronic problem with finding suitable managers in the care home system, the effects of which have caused widespread concern. For example, Cynthia Bower, chief executive of the CQC explained:

We know from experience that care services without leadership can struggle to address any problems that may arise (Community Care, 2010).

As I explained at the beginning of this Chapter, by treating the experience of negotiating access as a 'critical event', it provided me with three key 'discoveries'. The first discovery from my various sets of negotiations was to learn how difficult it



was to establish the roles, responsibilities and, therefore, accountability within the different parts that make up the care home system. As I have indicated, this was not helped by organisational structures and personnel constantly changing. The second and third 'discoveries' related to learning more about what it was like to encounter street-level bureaucracy at first hand. This was about learning something of the subtle repertoire of discretionary strategies available to street-level bureaucrats in response to requests from system outsiders. As I have illustrated, these strategies effectively disabled research activity from taking place in ways that were often hard to identify and therefore hard to challenge. As a consequence, it is worth exploring this topic in more detail for what it revealed about the field.

## **Systems and Strategies**

Wolff (2004) argues that organisations usually regard research requests as an unnecessary intrusion, but that they have no real reason to say 'no'. Therefore, reasons have to be 'invented and sustained'. Wolff (2004) outlines the repertoire of commonly-used tactics deployed by organisational gatekeepers. These include:

- Pass upstairs: the request is first passed to a higher level with a request for examination.
- Cross-question: the researcher is repeatedly asked for new presentations of the research goal and procedures.
- Wait and see: the matter is referred for resubmission, because experience shows that many enquiries sort themselves out.
- Allocate: times, roles and research opportunities are provided which the organization, from its own standpoint, considers suitable and appropriate (p.199).

All of these reactions were encountered at some point. For example, a care home manager of a private home responded to my initial approach and asked me to send further details, including evidence of ethical approval, which I did. After an email reminder, the manager forwarded me, in response, an email from a director of the company. This demonstrates graphically two of Wolff's organisational 'immune reactions'; 'pass-upstairs' (from the manager) and 'cross-question' (from the higher gatekeeper). The email [produced here *verbatim*] read:

Need confirmation from [the] university and confirmation of indemnity for any issues arising during and after research relating to residents families staff pct nurses or doctors  
Applicant waives right to claim against home company for any incidents occurring during and after research and insures against. Risks accordingly. Also CRB on applicant and approval of xxxxx social service plus meeting costs of social service staff involved and waving right to claims from social service for any legal costs that may arise at any time as a result of the research project. agreement of pct if any nurse involved and doctors.  
Lastly confirmation of capacity of participants and agreement of relatives. All participants and families to see final thesis. In draft form. We will also obtain our insurers comment

It emerged that the home was part of the private chain, mentioned earlier, which was experiencing certain problems and attracting complaints, some of which had been reported by the local media. This might explain why this gatekeeper's response was so defensive and, seemingly, designed to deter rather than facilitate research.

Details of ethical approval from both the university and county council had already been provided, including confirmation of CRB. This was clearly considered insufficient and a string of, apparently, arbitrary conditions were added. I informed the manager that I could not meet all the conditions. Acknowledging the defensive

mindedness, they explained that the company had been 'hurt' by negative publicity in the past. The outcome was that no interviews arose from this episode. For this organisation, involvement in research appeared to be regarded as risky. As a consequence, the organisation effectively denied its service users the choice to participate in a project which sought their views about an aspect of the service.

It was evident that certain senior gatekeepers could block research requests from the outset. However, where research was sanctioned at the highest level, staff lower down the organisation who were either unwilling or unable to say 'no' to involvement were left with a tricky predicament (Buchanan *et al.*, 1998; Wanat, 2008). Avoiding participation required the adoption of more oblique methods.

As outlined above, three common ways in which organisations respond to research requests are: 'pass upstairs', 'cross-question' and 'wait and see' Wolff (2004).

Interestingly, all three were evident in an email response received from one care manager, who had been nominated by her manager:

..just a few things I need to know before this can happen, have you been policed (sic) checked? have you got the go headed (sic) from the chief ex of the pct ..... Also you will need to get consent from the manager of the home and also the service user...

The care manager was entitled to be sure that the necessary approvals had been obtained. However, using the discretion available to her, she went further and created her own, seemingly arbitrary, rules whereby multiple permissions would be

required from both within and without the organisation. This was an effective response from someone who might have been in 'two minds' about participating. Without refusing directly, it had the effect of potentially stopping me in my tracks. For example, although I had been CRB checked, anyone familiar with 'police checks' would know that they can take weeks, often longer. Also, my needing to get the 'go ahead' from the 'chief ex of the pct' could not have passed the request any further upstairs. This form of questioning was the most comprehensive response of the 'cross-question' kind. However, the most common method was 'wait and see'. When followed up, either by phone or email, it was very common to be told 'I haven't forgotten about you' - a phrase which became more ambiguous the more frequently it was heard.

According to Wanat (2008) gaining access is a "continuous push and pull between fieldworker and informant" (p.193), observing that:

When all else failed, "forgetting" was an effective tactic. It seemed reasonable that gatekeepers, all busy professionals, might forget to help arrange an interview. After gatekeepers kept forgetting to perform tasks as promised, it became obvious that forgetting was a method of telling researchers 'no' while appearing to be cooperative (2008:204).

These observations resonate strongly with many of my field encounters. It appeared that reluctant participants believed that if they prolonged the 'push and pull' stage long enough, I would either have found participants from elsewhere, 'forgotten' them

or that I would get the message and stop badgering them. When asked about this perceived reluctance to participate, a senior social worker replied:

I think one of the main issues for workers is that they're constantly overworked.

Adding:

I think they [care managers] feel pressured. I don't get the impression that many workers take much pride in the work that they do.

Both of these reasons would explain why workers would not welcome a researcher observing them. In general, care managers appeared defensive about their practice, and protective of their time. In addition, staff shortages aggravated the pressures experienced by front-line staff. For example, a participant, aware of how difficult it had been to contact them, explained:

I have been so involved in some complex cases & also co-ordinating the review work it has been chaos.

## **'Screening'**

In the introduction I explained that my third 'discovery' was that discretion was not only exercised vertically but also horizontally in organisations and I linked this to the role played by 'screeners' as defined by Lipsky (1980). Later, I referred to a call handler in the County contact centre as a 'screeener' because they fitted the definition provided by Lipsky (1980) as workers who act as 'buffers between street-level

bureaucrats and clients' (p.128). This informal screening role has also been recognised in the research literature. For example, Wanat (2008) explains that:

Informal gatekeepers within the organization often protect research settings and participants, particularly vulnerable individuals (Wanat, 2008: 193).

The concept of the 'screener' can be usefully developed beyond the explanation that Lipsky provides. 'Screener' appropriately describes the role played by (mainly informal) gatekeepers in more than one way. To 'screen' has multiple shades of meaning. It can, for example, mean to act as a block, to guard or to protect and it can also mean to filter, to 'vet', to make a decision about or to assess the value or suitability of something. All of these meanings became conflated and applied in this case. The gatekeepers were screening (guarding) 'vulnerable' older people, screening (protecting) themselves and they were screening (assessing the suitability of) the research project. Another good example, of this informal and arbitrary screening activity occurred in one of my many phone calls to speak to a care home manager. The receptionist rather than simply pass my message on, decided to ask me what my call was about. When I provided details, as with the call centre worker, they took it upon themselves to examine my *bona fides*, asking me whether I had the permission of the local authority and when I replied that I had, asking 'what about the relatives?', adding that 'most of our people have got dementia or something like that'. To be fair to the receptionist, this could be seen as an attempt to protect 'vulnerable' residents. However, as with the situations described earlier, their authority to impose arbitrary conditions illustrated the discretion at their disposal, whilst also denying their residents the right to make their own choices about whether to participate or not. Screening in all of its shades of meaning had taken place.

The ambiguity attached to the concept of screening is important because, whilst there is no doubt that the care home managers had the authority to screen in the sense of protecting vulnerable residents from unnecessary risks, whether they or others working in care homes had the authority to screen in the sense of deprioritising the value of the research to the older people is doubtful. In doing so, the managers exercised their screening powers in ways which denied choice, opportunity and involvement to a marginalised group. However, precisely because of the ambiguous authority in respect of their screening role, it was impossible to know whether this was deliberate or not.

During much of the field negotiation, I was being kept out or kept waiting by various screeners and gatekeepers. However, in one instance, I was granted access almost accidentally because the actual manager was not there and the staff member delegated to deal with me was confused about what she should do exactly. Ironically, having been let in, I was given far more access than was ethical. As I was led around the home I did not feel that the privacy of the residents was being respected. In this case, the 'gatekeeper/screener' had actually failed to protect their field properly. In the process, I gained a valuable insight into how a member of the care home staff regarded residents' rights. Care homes represent a space where one group of people's home and another group of people's workplace meet (Peace *et al.*, 1997). In this case, a member of staff led a stranger into the residents' space with minimal thought and no preparation. It was clearly considered more of a workplace than a home.

As with all the homes approached, it appeared that most of those that I encountered knew little about social research processes but that, in the absence of any formal, thought-out protocols, individual actors made their own pragmatic responses apparently mostly based on intuition.

### **Final reflections on gaining access**

As suggested in the quotation by Wolff (2004) which starts this chapter, the discussion has used the access negotiations as a 'critical event' on which to reflect on what can be learned to better understand the statutory care home review system in the County. In this respect, certain key discoveries were made. For example, both the local authority and PCT were in a state of, almost continual, organisational upheaval during the period in question. Reorganisations meant that managers were changing roles within different organisational structures. The overall climate of change, uncertainty and associated stress in the locality teams was exacerbated by the need to absorb several key policy changes as discussed in Chapters Two and Five. Those working in the system expressed concern not only about the pressure of work but also about becoming deskilled. In such circumstances, their adoption of protective strategies towards outside enquiries, could, perhaps, be understood.

Care homes were also under stress in certain respects, experiencing both managerlessness and manager turnover, they were also stretched caring for residents with high levels of need. The reluctance, at times, of care homes to open themselves up to outside investigation needed to be seen in this context.



In recent years the care home system in England has been reported in the media as being 'in crisis' for various reasons (Telegraph, 2009; Times, 2009; BBC, 2010; Channel 4, 2010). These include: funding cuts; home closures; a rise in reported complaints (including complaints of abuse); a rise in reported critical incidents; staff shortages, high staff turnover, poor standards and poor access to health care. Seen against such a backdrop, care home-related research clearly becomes a sensitive issue. Thus, those employed in the care home sector could be forgiven for feeling a certain degree of caution in response to any research requests received. To an extent, this helps understand several of the apparent 'immune reactions' experienced. However, along the way, the field negotiations provided some insights into other aspects of care home cultures.

By definition, the older care home population is 'vulnerable' in one way or another. Older people would not normally reside in a care home unless they had complex needs. However, that does not mean that many do not have the mental capacity to be able to express their view about a review in which they had been personally involved. The issues around the perceived vulnerability of the residents, arguably, get to the heart of many of the access problems. It seemed that much of the delay in failing to identify participants was due to the feeling that the residents were vulnerable and therefore needed to be protected from risk. Given the allegations of abuse attached to care homes, this view could be considered laudable. However, very few participants were even considered, let alone put forward, over a relatively long period of asking. This was despite obtaining ethical approval which had, at its

heart, the need to ensure that all participants were not exposed to risk. The outcome suggests that the blanket of vulnerability had been thrown rather too indiscriminately over the residents, and that the risks to them of being interviewed seem to have been exaggerated. This is the point where the various screeners and gatekeepers can be most criticised. They might not, personally, have seen much value in the research, they were probably busy and selecting suitable residents would have taken some of their time. However, they do not seem to have seen it from the older person's perspective. The older people appear to have been solely constructed as of needing protection from threat rather than being offered the opportunity to talk about their experiences.

My experiences as a researcher trying to negotiate field access, arguably, provided me with valuable insights into what it feels like to experience 'people processing' and discretionary strategies of street-level bureaucrats (Lipsky, 1980). As a researcher I was not dissimilar to a client requesting a service. I submitted my request according to what I believed were the rules, but found that the outcome greatly depended on the discretion of first, screeners and then gatekeepers juggling priorities in a context of scarce resources. At times, it was obvious that 'rules' were invented to suit the needs of the gatekeeper at that time, in circumstances where their authority to do so was not always that clear.

Formal gatekeepers and screeners exercised discretion in a variety of ways that served to shield the system from scrutiny, protect organisational interests and manage the potential tensions that might follow from being researched. The

strategies that were ostensibly used to 'protect' 'vulnerable' care home residents actually denied the residents the opportunity to have their perspective heard which, in so doing, contributed to their marginalisation and passivity, as suggested in Chapter Seven, was maintained.

# **Chapter Ten: Conclusions**

## **Introduction**

The focus of Chapter Nine was specifically on what lessons could be learned from examining a specific part of the research process. The initial focus of this final Chapter is a critical reflection on my role as researcher more generally. I consider the challenges facing the researcher of working reflexively and examine as reflexively as possible, both the impact I have had researching the field and, in return, the impact on me as a researcher of the research experience. I conclude this part of the Chapter by reflecting on what I have learned about myself as researcher and what I would do differently if I were to undertake similar research again. In the second part of the Chapter I conclude by making certain suggestions for further research based on the issues raised in the study.

## **Reflections on the Research Process**

### **The reflexive researcher**

In Chapter Four, in discussing my relationship to the field as a researcher, I cited Smith (1998), who made the pertinent point that:

....in social science we are both the subject and object of our own knowledge. When we study social life we are also studying ourselves (p. 7).

I stated that I would, therefore, need to be aware of how my 'biographical situatedness' might affect studying the field. I went on to add that, as a

consequence, my time in the field would need to be negotiated with a 'high degree of reflexivity'. In social research, adopting a 'reflexive' stance is an important means by which subjective biases throughout all stages of the process can be exposed through self-scrutiny (Blaikie, 2010). However, as Denscombe comments:

Reflexivity is an awkward thing for social research. It means that what we know about the social world can never be entirely objective. A researcher can never stand outside the social world he or she is studying in order to gain some vantage point from which to view things from a perspective which is not contaminated by contact with that social world. Inevitably, the sense we make of the social world and the meaning we give to events and situations are shaped by our experience as social beings and the legacy of the values, norms and concepts we have assimilated during our lifetime (Denscombe, 1998: 240).

Like many others, Denscombe's assessment is that objective detachment in social research is, almost certainly, not attainable. Therefore, this discussion takes place recognising the philosophical challenges that can be made about the status of the knowledge produced in this study. However, because I want my findings to be credible, not only do I need to demonstrate that my findings and any interpretations I have made are grounded in the data, I also need to be as open as possible about what Denscombe calls the 'legacy of the values, norms and concepts' assimilated over a lifetime. To that end, as part of the discussion on methodology in Chapter Four, I highlighted key aspects of my biographical 'situation' that meant that, because of both personal and professional experiences, I did not approach the case study neutrally and 'unencumbered'. I exposed something of the 'political' processes influencing both my choice of research question and research design. I indicated

quite clearly that my rationale for choosing the research question was that, from personal experience, I was of the opinion that, from the point of view of the older person, statutory care home reviews were a flawed process. I also explained how I had worked as a social worker with older people, both before and after the community care reforms of the 1990s and, although I did not state it in Chapter Four, I am prepared to admit that, in common with many others cited in this work, I found the move towards care management to be over proceduralised and bureaucratised compared to the ways of working that preceded it. I also found myself frustrated by the introduction of quasi-markets into social care which seemed to be driven more by New Right ideology than a desire to meet the needs of older people.

Finally, I also declared that I was in a potentially complicated relationship with professionals I might encounter in the field as a researcher because of having worked in various roles in the County myself, not just as a practitioner but also as an educator. The potential implications that might follow from some degree of role conflict were acknowledged and I will return to discuss them in more detail later. All of these factors pointed to the possibility of significant subjective bias for various reasons. They were revealed to the reader in order that the findings could be read and interpreted in this context. However, without wanting to minimise the need for self-scrutiny, I support the view made by Hennink *et al* (2011) that researchers need to 'strike a balance, striving for self-awareness but eschewing navel gazing' (p.22.). Therefore, in the discussion that follows, I will try to ensure that my reflexive gaze is more focused in understanding the implications of my *relationships* with key actors in the field, rather than on myself alone.

## **Relationships with older people**

My reflections here concern my experiences in direct contact with older people as part of the research process. These include how these participants understood my role, their expectations about the research and the extent to which my involvement of them in this study might have contributed to any oppression, discomfort or any other feeling (positive or negative) experienced. An assumption underlying the research was that by shining a light on a specific area of the care home system, there might be some positive benefits that would emerge for older care home residents who found themselves in that situation. However, the fact of researching an area of provision need not produce benefits for the researched; it depends on how it is carried out and what is done with the results. In fact, in this case, I am left with feeling that, despite thinking through the ethical considerations before and during the research, it is possible that my research might have led to certain unforeseen, negative consequences for some of the older people involved.

In Chapter Eight I made critical comments about the potentially oppressive impact of reviews on older people. In earlier chapters I also described how relatives of older care home residents experienced negative or, at least, difficult emotions from their participation in the review process. However, there are parallels that can be drawn between the care home review and the research process, not least being the requirement that people disclose information about themselves to a stranger under conditions where there are imbalances of power. In both cases the informant has little control over the process. Reflecting on various implications of her own research

with frail elderly people, Hey (1999) firstly, makes this observation about the personal implications of researching older people:

Loneliness may well propel the elderly to disclose information in order to retain the company of the researcher. Subsequently, they may regret engaging in too much personal talk. We need to be aware of the power we hold as interested strangers who, having established trust and encouraged disclosure, can then move on. Leaving 'the field' may well mean consigning elderly people back to a heightened awareness of their social isolation. (*ibid*)

I would not necessarily say that I left the older people I interviewed or whose reviews I observed with 'a heightened awareness of their social isolation' although that is a possibility. If anything, my visit could well have reminded them that they were a (probably involuntary) recipient of welfare provision and this might have brought to the surface any feelings they might have had about that status. However, Hey's point about 'establishing trust', 'encouraging disclosure' and 'moving on' resonates for different reasons. Stripped down, the research process was basically, establishing enough trust to enter an older person's life, 'collecting data' from them, and moving on with, for the older person, little more concrete to show for the encounter than a 'thank you for your participation' and possibly a vague feeling that they might have helped 'my' research in some way. I have subsequently learned that both OP1 and OP2 have now died and I am not sure about the health status of the other three people. Therefore, whilst others might benefit in the future when the findings are reported, it is extremely doubtful that any of the older people who 'participated' will see a tangible outcome from the research personally.



The parallels between my encounters with older care home residents as a researcher and encounters between older people and care managers in reviews are clear. Whilst the older people had the choice about whether to participate or not, to pick up on Hey's point, they might well have agreed to participate more out of an opportunity to have some social contact with someone taking an interest in them rather than understanding what the project was about. Whatever their motives for participating, my unsolicited arrival in their lives, asking questions and seeking information relates to an equally relevant observation made by Hey about the political implications of researching the users of community care services:

By investigating 'community care' and its derivative professional health and social welfare actions, I too became inextricably part of an apparatus of power that bears down even within that apparently 'private' encounter known as an interview (Hey, 1999: 107).

In Chapters Three, citing Clarke (2004), and Nine, I talked about the multiplication of actors and the dispersal of power – and therefore discretion - in the current system of adult social care in the UK. I proposed that this made understanding how the system operated more opaque for both service users and their relatives. In some respects, to pick up on Hey's second point, the researcher researching users of adult social care becomes another powerful actor in the service user's lives, the use of whose own discretion potentially disempowers or oppresses those they encounter. Arguably, an example of this happening in this study was in the observation of the reviews of OP2 and OP3 both of whom lacked capacity. Firstly, they did not have

control over my being there, I had sought access through relatives (which, given their impairments, was an appropriate course (Lewis, 2003)), I introduced myself and, although I tried to be as unobtrusive as possible, my presence, on reflection, could well have added to their confusion about what was going on. I was yet another stranger to perform to, with its concomitant risks of performing incompetently. From the transcript, here is how I was introduced to OP3:

CM3: This is P (me)

OP3: Hallo P

Me: Hallo OP3. I'm tagging along with CM3 to see how these reviews go if you don't mind. Thanks for having me in

OP3: Yes

I had given full details and consent form to OP3's relatives which they had signed, but mindful of the need not to overcomplicate matters with OP3, and also not wanting to draw too much attention to myself, I tried to take the formality and potential threat out of my being there by the use of the phrase 'tagging along'. Whether this was successful I do not know. However, my presence meant that, altogether, four people had gathered around OP3 in her bedroom, which rose to five when we were later joined by the care home manager. I have no real idea of how much OP3 understood of the review process in which she was 'involved', although my analysis in Chapter Six suggested that she was somewhat disorientated at times. Her minimal responses had something of a placatory air about them. However, as I explained in Chapter Six, there were certain parts of her review where her failure to perform competently because of her dementia caused her discomfort. Her embarrassment in public certainly appeared to bother her son and daughter in law.

To have another stranger witness this might well have made the feelings more acute for both OP3 and her relatives.

The older people's experiences in their individual reviews link to a more general point about my visits to care homes, which is that residents did not always seem to possess much control over their privacy. Once in a care home, staff were sometimes only too willing to show me around, regardless of the feelings of residents, underlying the point that care homes are simultaneously a home for some and a work place for others (Willcocks *et al.*, 1987; Peace *et al.*, 1997) – hence, 'private lives in public places'. Every time I entered a care home I felt the potential to compromise the residents' sense of home and privacy just by being in their space.

Whilst they were 'willing' participants and broadly appeared to understand what my research was about, the three older care home residents with mental capacity that I interviewed, generally, had a guardedness about them which made me wonder about the 'truth' of what they were telling me. They can be forgiven for not remembering much specific about their reviews, apart from them being 'lots of questions', but, beyond that, in general conversation, whilst we covered a range of topics from TV viewing preferences to their relatives and their previous jobs, they were keen to stress to me that they were happy in the home and that they had 'no complaints'. I have no evidence to suggest that they were not happy in the home; however, I sensed that this type of response was a means of maintaining a degree of control over their situation. Similar to the cautious defensiveness observed in reviews, it appeared that the interviewee's circumspection about matters to do with

the care home in such encounters was aimed, pragmatically, at ensuring that no unwanted actions would take place as a result of my research.

The question of taking action, unwanted or otherwise, brings into focus certain specific ethical dilemmas that I felt as a researcher which emerged from different encounters in care homes. The most graphic example of this came when CM2 and Mrs OP2 were shown photographs by a senior member of staff of OP2 practically naked, which I also glimpsed. As discussed in Chapter Six, this was in the context of a discussion, initiated by CM2, concerning pressure sores on OP2's buttocks, which the staff member was keen to point out existed before OP2's admission. I thought that the taking and subsequent showing of these photographs amounted to a serious breach of OP2's dignity and I later shared this with a CSCI inspector who informed me that such practices were not uncommon. In the event, although I raised the topic in my interview with CM2 as discussed in Chapter Six, I took no further action. However, it brought home to me the problems with trying to maintain an appropriate level of researcher detachment in such situations. As I have indicated before, a researcher who witnesses and records oppressive practices but does little to challenge them is colluding with the oppression. However, a critical part of the dilemma is that a researcher does not necessarily have the automatic right to intervene on behalf of adults without their permission. In my role of social work educator, I caution against the temptation to engage in 'rescue fantasies'.

To balance the discussion I could argue that, far from oppressive, my agenda was 'worthy' in that, over and above the immediate goal of collecting data in order to

obtain a PhD for my own professional development, I was also undertaking research that might well benefit other older people in a similar position in the future. However, as indicated above, in order for any possible benefit to accrue, the findings and conclusions would need to be disseminated to the relevant stakeholder organisations involved in statutory care home reviews. However, dissemination alone would not lead to change, the organisations must be willing to 'hear' the messages and be able to respond appropriately. Given, the context in which they operated and the characteristics of the organisations, outlined extensively in previous Chapters, this would prove challenging. The challenges associated with effectively disseminating my research findings are also complicated for the reasons indicated above, that of potential role conflict resulting from the different ways in which I am known to some in the County.

## **Relationships with researched organisations**

### ***Formal relationships***

My relationships with researched organisations and those working within them were both formal and informal. The research relationship with the County was formalised through the County's *Research Governance Framework* which, despite receiving Ethical Approval from The Open University HPMEC, was an additional requirement for any research involving employees or users of County services. I therefore entered into a formal research relationship with the County, whose requirements concerning the methodological and ethical soundness of the research coincided with those of The Open University, as might be expected. However, there was a

particular condition in the County agreement that, as the research draws to a close, now poses for me certain ethical dilemmas. Under 'Dissemination' it was stated that:

It is a condition of approval that the research will be logged on the council's database. The council would also like a summary to be made available for the council's website.

As has been discussed throughout this thesis, the standard of much of the review practice observed in the County was of variable quality. Even though I have explained how the policy and organisational context created pressures for managers and practitioners, the findings have highlighted, amongst other things, practices that were, at best, 'briskly' undertaken and, at worst, inconsistent, negligent, oppressive and, quite possibly, ageist. This raises the question of how to feedback negative findings in a way that is constructive, palatable to the organisation and does not compromise the anonymity of participants. Obviously, such challenges are not uncommon for social researchers at the reporting stage and, in addressing this White *et al.* (2003) stress that:

Integrity in reporting requires a demonstration that the explanations and conclusions presented are generated from, and grounded in, the data. .... It is also important to be transparent about the process of analysis and interpretation so that audiences can follow through the processes of thinking that have led to the conclusions (p.289).

There are many audiences to which a researcher can disseminate their findings and their concerns should guide the format in which they are delivered (Silverman, 2005). In reporting back to the County, whilst integrity in reporting is important, the

commitment to preserve confidentiality and to maintain the anonymity of participants means that serious consideration needs to be given to how much of the fine grain of the data be revealed. Another consideration is that the only realistic means of rectifying any deficiencies in the care home review system would be by working with and through the relevant stakeholder organisations and this requires being able to couch criticisms of managerial and practitioner behaviour in terms that would not lead to a loss of trust. If any criticisms were reported in a way that were considered likely to damage the public reputations of any of the parties involved, conceivably, I might find myself reprimanded or excluded from future partnership activities. This outcome might even prejudice the chances of other researchers in the future.

In the circumstances, it would seem appropriate to confine myself to broad themes whilst making practical suggestions about where improvements might be made. However, as I made clear in the previous Chapter, the attitudes of managers and practitioners to care home reviews needed to be understood in their particular political, policy and organisational context. Therefore, the extent to which managers and practitioners might, realistically, be receptive to implementing measures that would be in conflict with current practices is debatable, especially at a time of cuts in funding. It also needs to be borne in mind that my research was not commissioned by the County, I was an independent researcher to whom they granted approval. This raises the dilemma of whether reporting back in this case should be seen as a ritual exercise and done minimally or whether I should make real efforts to confront the County with some of its areas of poor practice. My inclination is to compromise by supplying them with a brief, broad-themed report and to inform them that I would

be prepared to discuss in more depth on request. That approach would seem to be an appropriate ending to my formal research relationship with the County.

### ***Informal relationships***

While the formal relationship with the County as a PhD researcher may be drawing to a close, other roles I hold in the County mean that different relationships with the social care organisations researched will continue and it will be difficult to compartmentalise completely this project from other activities. On one level, my University (which is located in the County) expects me to disseminate my research in other formats, for example, in journals where the degree of detail would be much greater, and also to refer to my research in seminars and in teaching which includes post-qualifying courses for social workers. The University will also expect me to carry out further research which might also be focused on County provision. Therefore, the dilemmas around wanting to see some improvements in practice, to uphold integrity but also to maintain trust and preserve good working relationships will need to be worked out sensitively for a considerable time to come.

One of the important things that I have learned is that, whilst it might have looked an easier option, researching in one's own 'backyard' can lead to a tangled web of roles and also ethical dilemmas for the various reasons outlined. During the research process I encountered several managers and practitioners who knew me in other capacities, either as former colleague, social work educator or both. Most of the time, this did not present many problems of role conflict as these people understood that I was taking on a research role in order to complete a PhD. In fact, given the difficulties explained in Chapter Nine, a few of these contacts proved useful in making progress



with field negotiations. In other words, I capitalised on previous goodwill derived from other roles, which on reflection, has now blurred my relationships with these people and makes future contact potentially complex. I cannot but wonder whether the pragmatism I thought I could detect in much review practice was not equally detectable in the way I used various relationships in the field to further my own ends. However, as the pragmatism in reviews led to a compromised system, I am left to reflect on whether my pragmatic research role has not compromised my relationship with the social care organisations of the County in certain respects. For example, if I did publish the research in a journal at some point in the future, I cannot realistically see myself drawing it to the attention of those people in the County who participated in the research.

### **What would be done differently?**

Following on from the last point, it might be obvious that I would choose to look at another local authority rather than the one in which I was so embedded. However, that said, when the field negotiations were at their most stalled, I did seek permission to research a neighbouring county. In many respects it transpired that there were close parallels with my experiences with the County. I gained approval from that county's research panel only to find that none of the teams I approached was interested in participating. On a smaller scale, I encountered several of the 'immune responses' described in Chapter Nine. Therefore, although researching another local authority would have avoided the 'tangled web' of relationships, there would have been no greater guarantee of achieving successful field access and, it has to be

said, with less opportunity to seek pragmatic solutions off the back of pre-existing contacts.

Despite the setbacks, it was worthwhile pursuing answers to the research questions in this study and the case study design using mixed methods proved to be an appropriate means of providing the necessary answers. However, the data set is more limited than anticipated, particularly in respect of the inclusion of the authentic voices of older people, and this has led me to reflect whether I should have commenced the process via those care homes that were sympathetic towards the research, rather than the local authority. That way I might have gathered a number of willing older participants first and then sought the care managers' permission to observe a review. However, it would still have been difficult to know when reviews were going to take place because care managers are the people who organise them. Nevertheless, in retrospect, if I had gained the permission of the care home provider who showed themselves to be most sympathetic to the research (a local housing association), I could have made my case study from various statutory reviews that took place in the three homes that they ran over a period of time. That sort of strategy, potentially, would have given more control to the older people. However, as I made clear in Chapter Nine, due to their perceived and *de facto* vulnerability, older people in care homes are surrounded by 'screeners' of one kind or another, some with more authority to screen than others, therefore, it would still have been a complex task.

Methodologically, as well as wanting a larger data set, in terms of the mix of methods, I would have also liked to have a greater proportion of observations within the data. This was because I felt that observation allowed me to see the whole process first hand, yielded the richest data and was fundamental to better understanding organisational cultures. Whilst interviews provided several useful insights, I reiterate the point I made in Chapter Four, citing Atkinson and Silverman (1997) who argued that interviews are likely to provide constructed versions of the 'rehearsed' self and therefore cannot always be trusted to provide an authentic account of the interviewee's behaviour. Observation was valuable because it allowed me to compare what people said they did with what I actually saw them doing.

Lastly, on a practical note, on one occasion (crucially, the part of the OP3 review when the photographs were produced) there was no available power socket in the room and, because I had not fitted batteries in the digital recorder I was using, I failed to record the discussion and had to take notes, which were not as accurate. Therefore, I learned that when using any form of technology to prepare for the worst.

Overall, I seem to have spent quite a long period of time researching for a relatively limited amount of data from interviews and observations. However, treating the time spent negotiating access as another source of data and using it to analyse various organisational 'immune responses' has contributed significantly to understanding better the context in which statutory care home reviews take place. I am, therefore, glad that I turned the spotlight on a little known and, hitherto, completely unresearched part of the adult social care system and I believe that, in doing so, I

have met my research aim and objectives. Furthermore, it has allowed me to contribute something to wider debates about the exercise of discretion and Lipsky's ideas about 'street-level bureaucracy' in adult social work. My research also adds something to the critiques which have drawn attention to the flaws in transforming the system of public social care in the UK through the processes of marketisation, privatisation and commodification. As this study illustrates, these processes have fragmented the system, dispersed power and discretion and blurred accountability. This has important consequences for both safeguarding and providing good quality care for older people in care homes. This study also illustrates that the 'modernisation' and 'transformation' of adult social care, initiated by New Labour and continued by the Coalition, have not delivered the choice and control promised to service users in the rhetoric that accompanied them. These political considerations lead me to where further research in this area might be useful.

## **Suggestions for further research**

By focusing on statutory care home reviews, this case study has been located where local authority care management, independently run care homes and vulnerable older people in society intersect. Each of these broad and overlapping areas is a potential area for research. However, guided by this research, I would propose one topic under each of these broad areas that could usefully be researched further.

### **Locality authority care management**

In line with many other studies cited throughout this thesis, this research has confirmed that local authority care management remains a highly proceduralised and bureaucratised form of adult social work. In common with writers such as Postle

(2001; 2002) it has confirmed the tensions that care managers face in implementing ambiguous policy goals under conditions of scarce resources. However, this study has also confirmed the argument put forward by writers such as Evans (2010a) that, within this highly circumscribed form of work, not only is there still discretionary space available to practitioners in their day-to-day decision-making, but that, in order to shift some of the responsibility for resolving the dilemmas of street-level bureaucracy, managers actually expect care managers to exercise their 'professional judgement' (to quote the LTM). I have described the approach to most of the decision-making that I observed, variously, as 'pragmatic', 'contingent' and '*ad hoc*' and I have attempted to explain the reasons for such approaches, the increased intensification of work in adult social care being an important one. I also expressed the, albeit unevidenced, suspicion that a different attitude was adopted towards care home reviews than might have been made towards other social care activities such as assessments or reviews of older people living in their own homes. I conjectured that these lowered expectations in regard to the needs of older people living in care homes, is a form of ageism. The only 'innovative' initiative I came across in terms of review practice was the collation and sharing of review information with other bodies responsible for monitoring care standards in order to promote better safeguarding . This is certainly important, but to think of older people in care homes solely in terms of their need for 'safeguarding' potentially contributes towards their de-individualisation. To see older people only through the lens of 'vulnerability' and 'safeguarding' is reductionist and excludes other important dimensions of personhood, agency and citizenship.

In this context, more research could usefully take place to examine whether there are differential attitudes adopted by those who work in social care organisations towards older people in care homes and, if so, how these differences manifest themselves in practice. Any research in this area would need to examine not only organisational cultures but also the attitudes of individual practitioners in social care organisations. It was clear from my research that an individual worker's personal and professional values also shape how they exercised discretion in practice.

### **Research into the impact of privatisation on decision making about older people in care homes**

As explained in Chapter Two, the care home 'market' is now very much run along business principles. The proportion of commercially run care homes is increasing and, in the non-commercial care home sector, the number of local authority run care homes has dwindled and continues to dwindle. Therefore, the two main providers of care homes in the UK are 'for profit' operators and 'not-for profit' operators (such as housing associations). However, most organisations in the not-for profit sector need to make money to survive in a competitive care market, making the distinction between 'for-profit' and 'not-for-profit' sectors less clear cut. Interestingly, in the context of health care, Pollock *et al.* (2007) found that, in many ways, 'not-for-profit' organisations mimicked the behaviour of for-profit ones, in terms of cost reduction and pricing strategies.

In Chapter Two I referred to Pithouse's assessment that the distinctiveness of much public sector social work, has, since the 1980s, been gradually

transformed by the culture of the capitalist sector (Pithouse, 2002: 180).

Therefore, a critical question in a care market is the extent to which business logic colours care decisions. As explained in Chapters Five and Six, managers of care homes did not like to have people placed with them whose needs they thought they could not meet. Specific examples were found where an older person had complex needs or challenging behaviour. On such occasions, care home managers used reviews to discuss whether the resident should be transferred. In such circumstances, reviews become very consequential, not only for the older person whose place of residence is under threat, but also the care home and the local authority because of the cost, time and workload implications. Quite reasonably, care home managers indicated that such requests were inspired by the desire for the older person to be appropriately placed. However, in a context where discourses of need and business have been collapsed into each other, there was no way of telling how much any such decision was inspired by the fact that the resident was costing too much in terms of the fee the home was receiving and also by 'blocking' a bed that could be given to a resident who was easier to manage and represented better value for money.

Therefore, the study of the review process has raised the issue of exploring further the extent to which decisions made by care home managers about whether to request the removal of residents are influenced by commercial considerations and, if so, what the implications of this might be for older people who are the subject of such decisions.

## **Research into ensuring the effective involvement of older people**

In Chapter Two, it was explained how the care home population is becoming more frail, with more complex needs and that an increasing proportion of the care home population has a form of dementia. This study exposed the challenges of engaging effectively with older people who have some form of cognitive impairment. There are provisions under the Mental Capacity Act 2005 for Independent Mental Capacity Advocates (IMCAs) to be brought in under certain circumstances. However, my research revealed that in reviews involving older people who lacked mental capacity, no form of independent advocacy was used. In Chapter Eight I highlighted that, even if this form of provision were more widely available, it was not without its complications.

Therefore, I would suggest that it would be useful to involve care managers in research that enabled them to share their ideas about what constitutes good practice in communicating effectively with older people with cognitive impairments in situations where a prior relationship does not exist and where time is limited. As I indicated in Chapter Eight, it is probably unrealistic, given the pressured circumstances in which assessments and reviews take place to allow for much more time than is already available. Therefore, if some basic principles and techniques for good practice could be identified and these could be embedded into care management procedures, this would be an important step towards ensuring that reviews and other similar meetings were more empowering and less disempowering for the older people at the heart of the system.



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# **List of Appendices**

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2007-2009.

## **Participant Information sheet**

### **Title**

**How reviewers and older people in care homes understand and use statutory reviews.**

### **Background and purpose of the study**

People who reside in care homes and who are funded by their local authority must have their care placement formally reviewed at least once a year. One of the main reasons for having reviews is to ensure that people's care needs are being met and whether the care needs to be changed in some way. The purpose of this study is to investigate how care reviews are carried out and to gain an understanding of questions such as how the reviewer uses the review format, how the reviewer and resident communicate with each other, what kind of information is shared, how decisions are taken and, basically, how useful reviews are for those involved.

### **Who is organising the research**

Peter Scourfield works at the Faculty of Health & Social Care at Anglia Ruskin University. However, he is also a part-time PhD research student attached to the Faculty of Health and Social Care at the Open University.

### **The results**

All the findings will be made completely anonymous. All information relating to the study will be kept confidentially and securely at the researcher's office at Anglia Ruskin University, Cambridge. Any reports or papers that are written following the study will be thoroughly anonymised so that none of the participants' details will be identifiable.

### **Your Participation in the Research Project**

You have been invited to take part as someone who is due to be involved in a care home review. However:

1. You can refuse to take part. There is no expectation that you will be involved unless you really want to.
2. You can withdraw at any time, simply by informing the researcher (Peter Scourfield) or a representative of the care home.

The researcher proposes to sit in the care review as a non-participant observer in order to see how the review is conducted. During the review, the researcher proposes to both record the review and make notes where appropriate. However, only the researcher will have access to the recording. Information will be deleted as soon as the recording has been transcribed (written out). No participant will be identified. All information will be kept completely confidential. The identities of *all those* involved will be kept completely anonymous. As will the name and location of the care home. Once the review has taken place, the researcher would like to interview the main participants, at a time and place of their choice, to ask them more about how they thought the review went and whether they had any other thoughts or comments about the review. The final stage would be for the researcher to see the completed review paperwork in order to see how the review was written up and what further actions were indicated.

### **Contact for further information**

Peter Scourfield, Faculty of Health and Social Care, Anglia Ruskin University, East Road, Cambridge, CB1 1PT

Telephone: 0845 1962561 Email: [peter.scourfield@anglia.ac.uk](mailto:peter.scourfield@anglia.ac.uk)

The research is being supervised by Professor Sheila Peace and Ms Julia Johnson, Faculty of Health & Social Care, The Open University, Walton Hall, Milton Keynes, MK7 6AA. The supervisors may be contacted at 01908-654240 or [s.m.peace@open.ac.uk](mailto:s.m.peace@open.ac.uk)

YOU WILL BE GIVEN A COPY OF THIS TO KEEP,  
TOGETHER WITH A COPY OF YOUR CONSENT FORM

## How reviewers and older people in care homes understand and use statutory reviews.

### Participant Consent Form

Firstly, a check to see whether you are happy with the information

Please tick as appropriate

I have been given a copy of the information sheet ☐

I have had the opportunity to ask questions about the study ☐

My questions have been answered satisfactorily ☐

I understand that, if I agree to take part in the study, I am free to withdraw at any time, without giving a reason, and without it affecting me in any way ☐

I understand that any details recorded will be treated in complete confidence and stored in a secure place ☐

I agree that the information I provide can be used for educational or research purposes, including publication. ☐

### Agreement to participate

I agree to participate in the study

Name of participant: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name of researcher: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

If you need any **further information**, please contact:

Peter Scourfield, Faculty of Health and Social Care, Anglia Ruskin University, East Road, Cambridge, CB1 1PT. (Telephone: 0845 1962561; email: [peter.scourfield@anglia.ac.uk](mailto:peter.scourfield@anglia.ac.uk))

If you wish to raise any issues about any aspect of my research with a more senior member of staff, you can contact Professor Sheila Peace or Ms Julia Johnson, Faculty of Health & Social Care, The Open University, Walton Hall, Milton Keynes, MK7 6AA Tel: 01908-654240 or email [s.m.peace@open.ac.uk](mailto:s.m.peace@open.ac.uk)



## **Appendix 2**

### **Care manager (reviewer) interview topic guide**

The care manager interview was concerned with finding out:

1. How they thought the review had gone and why.
2. What they considered the purpose of reviews to be.
3. What they felt the key issues were that came up.
4. What action they took as a result of the review.
5. How they achieved a sense of who the older person was.
6. What their thoughts were about the care review system generally.

### **Older Person**

The focus on the older person was concerned with finding out:

1. How they thought the review had gone and why.
2. What they considered the purpose of reviews to be.
3. What they felt the key issues were that came up.
4. What expectations they had of any action being taken.
5. Whether they felt the review had any value to them.
6. How involved they were.

## Appendix 3

### Data collection timeline and supplementary information about data sources

#### Pilot (2007)

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Ethical approval granted by HPMEC 8<sup>th</sup> May 2007

#### 1<sup>st</sup> Observation - OP1 review at The Oaks

OP1 was a woman with mental capacity.

Review observation: 4<sup>th</sup> September 2007

Interview OP1 27<sup>th</sup> September 2007

Interview CM1 (reviewer): 28<sup>th</sup> September 2007

Completed review form\* received November 2007

#### 2<sup>nd</sup> Observation - OP2 review at Cherry Trees

OP2 was a man who lacked mental capacity

Review observation 26<sup>th</sup> October 2007

Interview CM2 (reviewer) 14<sup>th</sup> November 2007

OP2 – dementia prevented interview. Wife (Mrs OP2) declined.

Completed review form\* received November 2007

---

The Manager (CHM2) was not interviewed.

---

## **Completion of fieldwork (2009-2010)**

### **3<sup>rd</sup> Observation - OP3 Review at The Elms**

OP3 was a woman who lacked mental capacity

Review observation	7 <sup>th</sup> July 2009
--------------------	---------------------------

OP3 –dementia prevented interview

Interview with son and d/law (Rels 1 and 2)	16 <sup>th</sup> July 2009
---	----------------------------

Interview with CM3 (reviewer)	17 <sup>th</sup> July 2009
-------------------------------	----------------------------

Interview with CHM3 (home manager)	30 <sup>th</sup> July 2009
------------------------------------	----------------------------

Completed review form* received	August 2009
---------------------------------	-------------

### **Additional Individual Interviews**

#### **County Adults Social Care Managers**

Senior Social Worker (SSW)	21 <sup>st</sup> January 2009
----------------------------	-------------------------------

Locality Team Manager (LTM)	13 <sup>th</sup> March 2009
-----------------------------	-----------------------------

Area Manager for Planned Care (AMPC)	13 <sup>th</sup> March 2009
--------------------------------------	-----------------------------

Development & Policy Manager (DPM)	14th May 2009
------------------------------------	---------------

### **Regulator**

**Care Home Managers interviewed**

CHM1 (The Oaks)

15<sup>th</sup> June 2009

It was not possible to interview CHM2 (The Cherry Trees)

CHM 3 (The Elms)

23<sup>rd</sup> July 2009

CHM 4 (The Sycamores)

24<sup>th</sup> June 2010

**Relative**

Rel 3 (Daughter of resident at the Sycamores) 8<sup>th</sup> July 2010

**Older People**

OP4 (The Sycamores)

15<sup>th</sup> July 2010

OP5 (The Oaks)

23<sup>rd</sup> February 2011

**The Care Homes**

The Oaks (site of observation 1): A care home owned and managed by a local, charitable housing association.

The Cherry Trees (site of observation 2): A care home with nursing owned by a private company with three other homes in the area.

The Elms (site of observation 3): A care home with nursing owned by a private company with five homes in the area.

The Sycamores (where the manager (CHM4) was interviewed): A care home with nursing owned by a private company with ten homes in the area.

More detail about the three care homes where observations took place is provided in Appendix 4. This is information taken directly from the Regulator's (CSCI) web site at the time.

### **Significant developments**

April 2003 Fair Access to Care Services (FACS) implemented

January 2004 'Adult Protection' training began in the County for all social care staff

April 2004 Commencement of the process of integrating health and social care services in the County including the transfer of social services staff to PCTs.

November 2006 Adult social care in the County identified as 'coasting' and rated 'one star' by CSCI

October 2007 Mental Capacity Act 2005 implemented

May 2008. Single Assessment Process implemented

April 2009 Deprivation of Liberty Safeguards implemented

\* The review form used within the County was revised twice in 2008 and again in 2009 see Appendix

## **Overview of the County's Adult Social Care Services**

**Social care services in the County are provided by the County Council and National Health Service, working in partnership.**

[Source: the County Council website]

### **Commissioning (County Council)**

The County Council has a strategic, commissioning, quality and audit role. Many of the services for which it has responsibility are commissioned (mainly jointly with the NHS) from the *County Community Services NHS trust*. On the commissioning side, a simplified senior management structure (showing adult social care responsibilities) would be:

### **Service Director: Adult Support Services**

Role includes: strategic management and commissioning Adult Client side

### **Development and Policy Manager (Adult Client Side)**

Role includes: implementing policy developments, training and ensuring the quality of performance and good practice. This role also involves overseeing and designing the County's forms and recording systems for care. *INTERVIEWED*

## **Provider side [County Community Services NHS trust]**

"Social care service is provided for the resident population aged 65 and over. It provides needs-led assessment, support planning, commissioning of care packages, **review** and risk assessments. Specific social care interventions including: facilitating and supporting alternative accommodation options such as residential care, nursing care and sheltered housing schemes, identifying carers' needs, safeguarding of vulnerable adults (SoVA), social work interventions and supporting people to remain at home"

[Source: County Community Services NHS trust website]

**The responsibility of delivering these services in the County falls to 13 Area teams. A simplified team structure (which does not does not include administrative and health practitioners) would be:**

### **Locality Team Manager**

Role: overall management of the team, supervision of senior staff, responsible for budgets and performance. *INTERVIEWED*

### **Senior Social Worker**

Role: case holding (mainly complex), supervision of practitioners. *INTERVIEWED*

### **Care Manager\***

Role: care management i.e. needs-led assessment, support planning, commissioning of care packages, **review** and risk assessments. *INTERVIEWED X3*

\* In line with the introduction of personal budgets the job title changed to 'self-directed support (SDS) practitioner' in 2010. This was one of several organisational changes that took place over the period 2006-2011. For clarity's sake this overview does not chart these.

## Appendix 4

### Profile of the care homes in which the observed reviews took place<sup>28</sup>

#### The Oaks

Total capacity 31 places

Care home only (Dementia - over 65 years of age; Old age, not falling within any other category; Physical disability)

Type of ownership: Voluntary

Registration date: 8/11/1988

Provider: A Local Housing Society Ltd

**The Oaks** is owned and managed by a local Housing Society, a charitable housing association. The home is situated to the north of the city centre. There are shops, a post office and a library nearby ..... **The Oaks** was purpose built for older people in 1988 and offers mostly permanent care. There is also a busy day centre. It is a pleasant modern building, built around a central courtyard. All have bedrooms ensuite facilities. Charges vary between £425 and £522 per week.

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<sup>28</sup> Source: Information on each of the homes is based on actual reports download contemporaneously from [www.csci.org.uk](http://www.csci.org.uk) (now part of the Care Quality Commission (CQC))



This inspection was the home's key inspection for the year 2006/7. It was unannounced. The inspector interviewed four residents, one visiting relative, three members of staff and the manager. A brief tour of the home was undertaken and a range of documents was viewed. The inspector also received twenty-two comment cards requesting feedback about the home, completed by residents and their relatives. Most respondents were very pleased with the overall service provided at **The Oaks**, although one resident felt the choice of food she could have as a diabetic was limited and another resident was disappointed they could not get access to digital television.

#### **What the service does well**

This home provides an excellent service that is clearly appreciated by its residents. Activities continue to be frequent and varied, and residents are actively consulted about all aspects of daily life in the home. Staff morale is good, and staff training and support is given a high priority. The home is led by a respected, competent and experienced manager who values the individual needs and rights of residents.

#### **What they could do better**

Fire doors must not be held back as this prevents them closing fully in the event of a fire, thereby putting residents' lives at risk. Residents' medication administration records should be checked regularly so that minor discrepancies in recording are picked up quickly (CSCI Report October, 2006).

## **The Cherry Trees**

Total capacity 40 places

Care home with nursing (Dementia - over 65 years of age; Mental Disorder, excluding learning disability or dementia - over 65 years of age; Old age, not falling within any other category)

Type of ownership: Private

Registration date: 5/6/1997

Provider(s): XXXXX Homes Limited

Situated in a residential area on the south-eastern outskirts of the city, **The Cherry Trees** was purpose-built to accommodate forty service users. The home has three floors, connected by a lift and stairs. The kitchen, store rooms and staff facilities are on the top floor. Nursing care is offered on the middle floor, and the ground floor accommodates older people with dementia. Most of the bedrooms are single rooms and all have ensuite facilities. There are lounge and dining areas on both floors, as well as bathrooms and offices. There is a good size parking area to one side of the building, and attractive, enclosed gardens to the other side and at the back. **The Cherry Trees** is one of the main roads into the city centre, which is about a ten minute drive away. ....In a questionnaire completed before the inspection the manager said the fees ranged from £535 to £800 per week.

## **Summary**

This is an overview of what the inspector found during the inspection.

We carried out an inspection of **The Cherry Trees** using the Commission for Social Care Inspection's methodology. This report makes judgements about the service based on the evidence we have gathered. Before the inspection we sent a questionnaire to the manager for her to give us some factual information about the service. We also sent some survey forms for the manager to give out, so that the people who live at **The Cherry Trees** and their relatives could tell us about the home. We received eight responses from relatives. People only had good things to say and these are included in the report. Our evidence also includes an inspection of the home which two inspectors carried out on 04/05/07 between 07.45 and 13.10. During our visit we spoke with residents, visitors, staff and the manager, had a look round the building and checked some of the records kept by the home. There were 40 people at the home, so there were no vacancies.

#### **What the service does well:**

People we spoke to, and relatives who responded to our questionnaire made lots of positive comments. These included:

"I love it here – I'm a very satisfied customer. There's not a single one [staff] who I can criticise. The food is excellent. I'd recommend the home to anyone – they'd get all the care and attention they need."

"The staff are very helpful, very kind, very nice. My friend is very happy. [As

a visitor] I'm always made welcome. Nothing could be better"

"I'm getting on very well here – very comfortable. There's enough to do, the food's very good and my room is clean. The staff are very helpful and the manager is very good – she tries very hard."

"My father and I are both extremely satisfied with the care our relative receives at this home. They treat all of us extremely well and we get on very well with all members of staff who are always, kind, pleasant and helpful."

"The care and respect shown to the residents is quite outstanding. The home manager and her staff are very special."

"I find this nursing home very welcoming, friendly, has a good feel about it when one visits. It has, in my opinion, improved [over 6 years]..... on the whole a good and lovely home, I'm pleased with it."

"My relative has been at the home for 2 months. I am very pleased with the accommodation and care provided so far."

"We are fortunate to have found such an excellent home for my mother."

"Main plus is the staff, their kindness, concern and cheerfulness".

A professional we spoke with, who visits a number of homes in the area, said "I would use this home for a relative if needed".

Staff told us they enjoy working at the home. Thorough assessments of people's needs are carried out so that people know their needs will be met, and information is available about the home. Care plans have improved and risk assessments are carried out, so that people's personal and health care needs are met. The home

refers people who live there to the dietician, and she visits on a regular basis.

Generally medication is handled well. The home provides a wide range of activities and entertainment for residents, visitors are made welcome at the home, and residents are able to make choices in all aspects of their lives. People described the food as excellent. The home's complaints procedure is well advertised and people are confident their concerns, if they have any, will be listened to. Staff have all received training and are clear about safeguarding vulnerable people.

The home is well-decorated, well-maintained, clean and homely, and smells fresh throughout. There is a good number of staff, who have been recruited well, and offered a wide range of training opportunities. The manager is competent and runs the home well.

#### **What has improved since the last inspection?**

The home has again shown improvements in a lot of areas. Four out of the five requirements made at the last inspection has been met. The majority of medicines are now stored correctly; residents' privacy and dignity is respected and appropriate personal care is offered; staff have received training in Protection of Vulnerable Adults; the carpets have been replaced and the home smells fresh.

#### **What they could do better:**

Only two requirements have been made following this inspection: medication (creams) must be stored safely, and recording of medication must be done

correctly so that all medicines are accounted for. Staff must receive regular supervision (CSCI Report May, 2007)

## **The Elms**

Type of registration: Care Home

Type of ownership: Private

No. of places registered 68

Category(ies) of registration, with number of places: Dementia – over 65 years of age (1), Old age, not falling within any other category (68)

### **Brief Description of the Service:**

The Elms is a purpose built home situated in grounds in a quiet lane close to the centre of the village of XXXX. Accommodation is arranged in flats, and each flat has a kitchenette and lounge area. There is a large communal lounge/dining room on the ground floor. Individual accommodation is on two floors with the upper floor being accessed by a passenger lift or stairs. The home provides care for older people with both social and nursing care needs. There is a day centre on site and the home has ambulance bus transport available for outings. An extension was built and this was registered with CSCI in January 2007. This increased the number of places they can provide by 20 to 68 people, of which, a maximum of 42 can also have nursing needs. The home is situated approximately 1 mile away from the centre of XXXX and 5 miles from the centre of YYYY. There are local

shops, pubs and a post-office in XXXX, and a full range of shopping and entertainment facilities in YYYY. Fees for the service range from £600.00 to £760.00 a week. Extras are charged for additional items such as chiropody and hairdressing.

### **What the service does well:**

Staff are polite and respectful to people living at the home. Comments we received about the home and staff who work there include, "the staff are always friendly and approachable", "staff attentive. Appear respectful and caring", "the staff are very caring and gentle in their approach in their dealings with my mother" and "the cheerfulness and friendliness of the staff are certainly helping". An assessment is obtained before people go to live at the home to make sure staff there are able to care for them. Most people said there is enough information provided about the home for them to make a decision about whether to live there. Every person living at the home has a care plan to show staff what they need to do to help that person. The plans are written to show what people can still do for themselves and tell staff members what they need to do for that person. One person said, "I'm made comfortable and provide for my needs as much as they can". People have access to health care professionals, such as opticians, chiropodists, GPs and community nurses. There is a dedicated activities co-ordinator at the home who makes sure there is always something for people to do, if they want to. People living at the home are able to choose what they do during the day, and this includes staying in their room if they want. The home helps people keep in touch with their relatives, and one visitor said, "the organised activities are very good". Meals are appetising

and people we spoke to said they like them and they are happy with the choice. One person returning a survey said the meals had, "Food is good with reasonable selection" and a visitor said, "The range and quality of food is excellent". The home is clean, tidy and smells pleasant. Regular maintenance and servicing checks are carried out and it is a safe place for people to live. Complaints are dealt with properly and everyone we received information from said they know how to and who to make a complaint to or talk to if they had any concerns. People who live at the home said they feel safe living there. The manager is a registered nurse and has other qualifications in management and dementia care. She has been working at the home since December 2005. Records are kept to show money kept by the home on behalf of people living there. This means that there is information to show when money is spent and what it is spent on, so that people can feel safe in having the home take care of it. There are enough staff at the home to be able to give people the care they need. Everyone living at the home who returned a survey said they get the care and support they everyone we spoke to said there are usually staff available when they are needed.

#### **What they could do better:**

We only made one recommendation at this inspection. We think that all staff members should have training in abuse awareness. This is so that they are all aware of the different types of abuse and how to recognise this. Not all care plans are updated when information changes. We talked to people about the care they need and staff members. They were all able to tell us up to date information, but it is important for care records to be up to date in case care staff who don't know



people have to care for them. Not everyone at the home is able to easily let staff know what they want.

(CSCI Report December, 2008).

## **Appendix 5**

**Review forms in use by the County over the data collection period.**

1. SOC 310 In use from Oct 2000
2. SOC 310c Residential Care Provider Information Sheet
3. SOC 368c In use from April 2008
4. SOC 368 In use from August 2008
5. SOC 368 In use from January 2009

[For completion by Care Co-ordinator]

Name of Service User:

Date of Birth:

SWIFT Id:

Date of Review:

Date of Previous  
Review:

Review Participants:

[Information sheets from provider, current SOC 311 and 302 to be taken to review]

**A QUALITY ISSUES**

*(Care co-ordinator may feel it more appropriate to discuss these in private with resident before the review meeting)*

- 1 Do the staff provide the help in a way that the client is happy with?  
Are there any issues or problems?

- 2 Is there enough choice about food and times of meals?

Yes ☐

No ☐

Sometimes ☐

How could choice about food and times of meals be improved?

- 3 Does the client have the chance to follow his/her religious beliefs, hobbies and interests both in the Home and by going out?

Yes ☐

No ☐

Sometimes ☐

What other opportunities would the client like?

- 4 Can the client choose what time to get up in the morning, go to bed at night and where to spend the day?

Yes ☐

No ☐

Sometimes ☐

What would the client like to be different?

5 Can the client choose when to be alone and when to be with other people?

Yes

☐

No

☐

Sometimes

☐

Comments:

6 Does the client have the involvement they wish in the running of the home; for example, membership of a residents' committee?

Yes

☐

No

☐

Sometimes

☐

How would the client like more involvement?

7 Is the client happy with how he/she is spoken to or treated by staff - for example, do they knock on the door before entering? Do all staff use the name the client prefers?

Yes

☐

No

☐

Sometimes

☐

What would the client like to be different?

8 Is the client satisfied with the equipment and facilities available at the Home?

Yes

☐

No

☐

Comments:

9 Does the client know how to make a complaint if things go wrong?

Yes

☐

No

☐

## B NEEDS AND SERVICES

1 Since the last review, have the client's needs, level of functioning or circumstances changed significantly?

Client View:

**Family View:**

---

**Provider View:**

**Others:**

- 2 Does the Home's current care plan reflect changes in need and is it being implemented?**
- 2.1 Is the help being provided appropriate to the needs of the client or is something different needed?**

**Client View:**

**Family View:**

**Others:**

**C FINANCES**

**1 Is the client receiving all the benefits to which he/she is entitled?**

**2 Is the client satisfied with the way his/her financial affairs are handled?**

**Yes** ☐

**No** ☐

**Sometimes** ☐

**If not, how could they be improved?**

**3 Have there been any changes in the client's financial situation since the last review?**

**Yes** ☐

**No** ☐

**If so a financial re-assessment is needed?**

**Yes** ☐ **No**

☐

**D SUMMARY AND ACTION PLAN**

- 1 Does the present placement meet the resident's needs or is a different setting required?**

**Client View:**

**Carer View:**

**Care Co-ordinator View:**

**Others:**

- 2 Should anything within this placement be changed – eg care plan, activities etc.**

- 3 Would the client benefit from access to an Independent advocate?**

4 Summary of Action to be taken as consequence of review.

Action

By Whom

Date of Next Review: .....

Signed: .....  
(Client or Representative) Print Name

Signed: .....  
(Care Co-ordinator) Print Name

**FOR OFFICE USE ONLY**

Recommendations agreed by Team Manager. Yes ☐ No ☐

If not, steps taken:

Date:

Shortfall form (SOC307) completed ☐

Purchasing Unit informed of change in placement  
or price (if applicable) ☐

Purchasing Unit informed of change in charge to  
client (if applicable) ☐

Signed: .....  
Team Manager

**SWIFT**

Date:

Review entered on to SWIFT ☐

Altered provisions entered on to SWIFT ☐



**ADULT REVIEW - RESIDENTIAL CARE PROVIDER INFORMATION SHEET**

*[To be completed in advance of review and given to Care Co-ordinator]*

Name of Client: \_\_\_\_\_

Name and role of person  
providing information: \_\_\_\_\_

Is this the first Review? \_\_\_\_\_

If not, date of last Review: \_\_\_\_\_

- 1 Has Client had any periods in hospital since the last Review?  
If yes, give dates and reasons for admission.

\_\_\_\_\_  
\_\_\_\_\_

2 Medication

Does Client take charge of own medicines?

Yes

Could he/she?

Yes

- 3 Has he/she had any contact since the  
last review with:

Does he/she need to?  
(4 tick box)

		Dates:	Yes	No
GP	<input checked="" type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dentist	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Optician	<input checked="" type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Chiropodist	<input checked="" type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapist	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Visual Impairment	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Community Nurse	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Social Worker	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Physiotherapist	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

- 4 Have you noticed any changes in his/her general health?
- 5 Have social contacts been maintained with friends, relatives and others? Any comments?
- 6 What is the communication/contact like between staff and the Client's family and friends?
- 7 How have the Client's needs or circumstances changed since the last review?

*[Please attach copy of the Home's current care plan]*

Thank you for completing this form.

**ADULT REVIEW OF NEED(S)****1.0 SERVICE USER DETAILS****Full Name:****Date of Birth:****SWIFT ID:****Date of this Review:****Date of last review / re-assessment:****Services related to this review (tick box(es))**Domiciliary service ☐Residential Care ☐Supported Living ☐Direct Payment ☐Nursing Home ☐Day Service ☐Individual Budget ☐Sensory Equipment ☐Other (specify) ☐**Type of Review (tick box) :** Meeting ☐ Telephone ☐**Change of details (eg Accommodation/GP/Name/Relationship Status )**

Change Type	New Details	Date of Change

## 2.0 REVIEW INVOLVEMENTS

(Include reviewer details and tick to confirm that Service User has consented to content of review being shared)

NAME	ROLE/ RELATIONSHIP	CONTACT DETAILS	INVITED	ATTENDED	CONSULTED	CONSENT GIVEN
			Yes	Yes	Yes	Yes
			Yes	Yes	Yes	Yes
			Yes	Yes	Yes	Yes
			Yes	Yes	Yes	Yes

## 3.0 RE-APPRAISAL OF CURRENT CARE PLAN

(Current SOC 311 / SOC 367 forms, Care Plan and last Review form must be available at this review)

**What progress has been made in achieving / meeting the outcomes shown in the Service User's current Care Plan?**

- the views of the Service User, provider(s), Review Officer, Assessor and any others must be recorded here
- record any views on the quality and effectiveness of service(s) being provided (Contracts and Care Placements unit must be told about any significant concerns and issues)
- record how the Care Plan supports and enables the Service User to achieve his or her outcomes

**Have the Service User's needs changed?**

- summarise any changes in need and risk factors (including increases/decreases in need)
- describe reasons for change (including changes in circumstances)

## 3.0 RE-APPRAISAL OF ELIGIBILITY

Using the 'Fair Access to Care Services' eligibility criteria below, tick and briefly describe the Service User's current eligibility status.

**\*\* Service Users with 'substantial' or 'critical' levels of need may be at significant risk. If this is the case, describe how the Care Plan can significantly reduce the risk.**

	LEVEL OF RISK			
Needs	Low (1)	Moderate (2)	**Substantial (3) **	**Critical (4)
<b>A</b> Physical safety of the individual or others				
<b>B</b> Physical health /disability of the individual or others				
<b>C</b> Mental health of the individual or others				
<b>D</b> Independent living skills				
<b>E</b> Involvement in work, education, training				
<b>F</b> Social roles, relationships and responsibilities				

**Is the Service User still eligible for services? Yes**

**If 'No', what action has been taken?**

**Does the current provision meet the needs and objectives? Yes**

**If 'No', what action needs to be taken – and who will do this? (Complete SOC 1726 (Service Shortfall form) if appropriate)**

**Is a full re-assessment needed? Yes**

**If 'Yes', what action has been taken?**

**(If 'No', but minor changes are needed to ensure the Service User is able to achieve his or her outcomes, record these changes in the Assessor's/Reviewer's summary)**

**Are the services of an IMCA needed? Yes**

If 'Yes' , use a SOC 1708 (Assessment of Capacity) form, and indicate this in the 'action' box.

#### 4.0 SUMMARY OF REVIEW

Service User's view of needs, and the care provided to meet them:

Informal Carer's view:

Provider's view:

#### Assessor's /Review Officer's summary :

Should the care package continue as it is, be reduced, or extended?

Have any new outcomes been added to the Care Plan –or should there be?

Is the Care Plan / care package still appropriate

Does the Service User know how to :

Make contact with the Council?  
(If 'No' – provide contact details)

Yes

Make comments or complaints?  
(If 'No' – what action has been taken?)

Yes

Make sure the Service User knows about benefits he or she may be entitled to claim by discussing the following checklist with him or her:

Is the Service User receiving all the benefits he or she is entitled to? Yes  
If 'No', what action will be taken?

**Have there been any changes in the Service User's financial situation since the last review? Yes**

**If 'Yes', describe these**

**Is a re-assessment of the Service User's finances needed? Yes**

**If 'Yes', complete and send to Financial Assessment Team:**

- SOC 311 (FC) Referral for Fairer Charging Assessment form (Domiciliary Care/Supported Living services)
- SOC 336a – Referral for Financial Assessment (Residential Care services)

**Does the Service User have any outstanding debts with the Council? Yes**

**If 'Yes', what is being done to help the Service User clear them?**

### **Independent Living Fund**

**Is the Service User in receipt of financial help from the ILF? Yes**

**If 'No', would the Service User be eligible? Yes**

**If 'Yes', would the Service User like more information about the ILF? Yes**

**If 'Yes', provide the Service User with contact details for ILF**

### **Direct Payment**

**Does the Service receive a Direct Payment? Yes**

**If 'No', would the Service User like to consider receiving a Direct to replace some, or all, of the services he or she is currently receiving? Yes**

**If 'Yes', give the Service User the 'DP2' booklet ('Direct Payments – Your Questions Answered') and information about the Direct Payments support organisation (DPSS).**

**If 'No', give reasons**

**Would the Service User like to be referred to the support organisation DPSS? Yes**

**If 'Yes' when will this be done?**

## Carers

Informal Carers who provide regular and substantial care are entitled to have an assessment of their own needs carried out, and should be encouraged to do this.

Is there an informal Carer supporting the Service User? Yes

If 'Yes', has the informal Carer been offered an assessment (or re-assessment) of their own needs? Yes

If 'Yes', was the offer of an assessment / re-assessment Accepted

If 'Declined' give reasons

(Carers Assessments policy and procedure is available here)

### LEARNING DISABILITY PARTNERSHIP ONLY

Does the Service User have a Health Action Plan? Yes

If 'No', would the Service User like a Health Action Plan? Yes

Has a person-centred plan for the Service User been completed? Yes

## 5.0 OUTCOME OF REVIEW

ACTION TO BE TAKEN	BY WHOM	WHEN



**Details of proposed Care Plan following review:**

**Consider :**

- the Service User's current / identified needs
- the objectives
- the outcomes

**Date of next review:**

**As part of my review, I agree to information about my care needs being requested from, and shared with, the caring agencies and health care professionals involved in providing the care I need**

YES ☐ NO ☐

**I consent to a copy of my complete review record being shared with everyone who has contributed to it (see page two)**

YES ☐ NO ☐

**SIGN HERE TO CONFIRM THAT THIS REVIEW HAS TAKEN PLACE :**

..... DATE: .....  
(Service User)

..... DATE: .....  
(Reviewer)

**SERVICE USER'S AGREEMENT TO CONTENTS OF REVIEW**

**(This section should be sent to the Service or his/her representative when the Review has been completed)**

I have received a copy of my review YES ☐ NO ☐

I understand and accept the results of my review YES ☐ NO ☐

What has been recorded in my review is an accurate statement about my social care needs YES ☐ NO ☐

**Comments:**

.....

.....

.....

.....

.....

.....

**Signed:**

.....  
(Service User / Carer – delete as appropriate)

**Print Name:**

.....

**Date:**

.....

OFFICE USE ONLY

Signed: ..... Date: .....  
(Assessor / Reviewer)

Print Name: .....

Job Title: .....

Team/Unit: .....

Signed: ..... Date: .....  
(Authorising Manager)

Print Name: .....

Job title: .....

Details of re-assessment entered on SWIFT Yes Date

Review entered on SWIFT Yes Date

Altered provisions entered on SWIFT Yes Date

Date of next review entered on SWIFT Yes Date

Data quality report printed from SWIFT: Yes Date  
(showing no errors or checked electronically  
by manager)

Copy of review sent to Service User: Yes Date

Unmet needs form completed (if appropriate): Yes Date

Copies of review sent to review participants Yes Date  
(see section 2)

If 'No' – copies must be sent once Service  
User's consent given

Actions/Recommendations agreed by Yes Date  
Practice / Locality manager

If 'No' – what steps have been taken?

Signed: ..... Date: .....  
(Practice/Locality Manager)

## **COMPLETING REVIEWS – GUIDANCE NOTES**

The following questions can be used as an “aide-memoire” to support you when carrying out reviews. Not all of them will be relevant, as much depends on the type of review being carried out – eg: reviews of service users living in residential care, and reviews of people living at home receiving community care packages. You should select which questions are the most appropriate ones to consider. You may also need to ask questions which don't appear below.

During reviews, Service Users, their Carers (both formal and informal) - and any other people involved - should be encouraged to offer their own perspectives and views about the services being provided. These should be recorded on review forms.

Current social care assessment forms (SOC 311, SOC 367) must be taken to reviews and referred to during the review itself.

### **GENERIC QUESTIONS TO ASK**

- What progress has been made since the Care Plan was implemented?
- How well does the Care Plan support the Service User in meeting his or her outcomes and objectives?
- How well are providers/formal Carers supporting the Service User's identified needs?
- How effective is the package?
- What does the Service User think about the quality and type of service provided?
- Have the Service User's care needs changed? If they have, have any risks been identified as a result?

### **QUESTIONS TO ASK ABOUT COMMUNITY CARE PACKAGES**

- Are Carers respectful and polite towards the Service User?
- Are Carers reliable and punctual?
- Do Carers spend the amount of time allocated for the Service User with him or her?
- Are there any access problems?
- Does the Service User have regular Carers – or is there a high turnover of them?

### **QUESTIONS TO ASK ABOUT RESIDENTIAL AND NURSING CARE, AND SUPPORTED LIVING**

- Do staff at the establishment have enough information about the Service User?
- How do staff at the establishment involve the Service User in making choices about:
  - his or her own care?
  - activities?

- social contacts (seeing family, friends, and other people living at the establishment?)
  - his or her own environment?
  - what he or she wants to eat and drink?
  - comforts?
- Are Carers respectful and polite towards the Service User – do they demonstrate respect for the Service User's dignity and privacy?
  - Are the Service User's religious beliefs, hobbies and interests catered for?
  - Is adequate and appropriate equipment available

### **QUESTIONS TO ASK ABOUT SOCIAL OR DAY ACTIVITIES**

- Do staff respect the people they work with – do they demonstrate respect for their dignity and privacy?
- Are objectives and outcomes being met?
- Have other ways of meeting social care needs been considered (eg, individualised budgets, Direct Payments)? If not, should they be?

### **QUESTIONS TO ASK ABOUT PROVIDERS**

- Do Carers complete care notes after each visit (reviewer to cross reference with care notes left at Service User's home)?
- How do Carers ensure that objectives and outcomes are being achieved – and what impact is this having on the Service User?
- Does the Service User have a regular carer – or several different ones?
- Are there any moving and handling issues?

### **QUESTIONS TO ASK ABOUT ADULT PROTECTION**

- Have any concerns been identified or raised about adult protection? If so, has using the Protection of Vulnerable Adults procedure been considered?

### **OTHER QUESTIONS**

- Is an Advocate involved in the care of the Service User? If not, should there be?
- Does the Service User make use of assistive technology? If not, should this be considered?
- Is the Service User employed – and earning the minimum wage? If so, the number of hours worked weekly should be noted, using these categories:
  - thirty hours
  - sixteen to twenty nine hours
  - five to fifteen hours
  - zero to four hours

**ADULT REVIEW / RE-ASSESSMENT****1.0 SERVICE USER DETAILS****Full Name :****Date of Birth :****Swift id :****Review /  
Re-Assessment date:****Date of last Review/  
Re-assessment****Services related to this review/re assessment (tick box(es))****Domiciliary service** ☐**Nursing Home** ☐**Supported living** ☐**Day support** ☐**Direct Payments** ☐**Residential Care** ☐**Sensory Equipment** ☐**Other please specify****Type of Review/Reassessment :** **Meeting** ☐**Telephone** ☐**Change of details eg – Accommodation/contact/GP/Name/Relationship Status or other please specify:****New Details****Date of Change****2.0 REVIEW INVOLVEMENTS**

NAME ROLE AND RELATIONSHIP	Attended = A Consulted = C Invited not attended = I	Consent given by service user to share content of review

### 3.0 RE-APPRAISAL OF CURRENT CARE PLAN

**When referring to your current care plan tell us what has been achieved and what outcomes have been met?**

You, (and your informal carers where appropriate), may want to consider

How the care plan has supported you and any informal carers you may have.

Comment on the quality and effectiveness of any service you receive.

**Have the outcomes changed on your care plan? If so tell us the reasons and circumstances for change. Your care manager/review officer may need to complete a risk assessment, but this will be explained to you.**

**In summary, are there any other comments you, or anyone involved in your review would like to make?**



#### 4.0 RE-APPRAISAL OF ELIGIBILITY

The chart below is the 'Fair Access to Care Services' eligibility criteria. Your care manager/review officer will explain how it is used to identify eligibility, and then briefly describe your eligibility status in the appropriate box(es).

Description of Needs	LEVEL OF RISK			
	Low (1)	Moderate (2)	**Substantial (3) **	**Critical (4)
<b>A</b> Physical safety of the individual or others				
<b>B</b> Physical health /disability of the individual or others				
<b>C</b> Mental health of the individual or others				
<b>D</b> Independent living skills				
<b>E</b> Involvement in work, education, training				
<b>F</b> Social roles, relationships and responsibilities				

4.a: Is the service user still eligible for service ?

4.b: Does the current provision meet the needs and support the outcomes?



You only need to answer the following questions relevant to yourself.

## 5.0 RE-APPRAISAL OF FINANCE AND BENEFITS

Ref no		Yes	No
5.a	Have there been any changes in your financial situation since your last Review / re-assessment?		
5.b	Is a re-assessment of your finances needed? This may include a benefits check.		
5.c	Do you have any outstanding debts with the Council? If yes, is there any support being provided / offered for debt management?		

**6.0 INFORMAL CARER** – this could be a family member (both adult and young carer) or friend who provide regular and substantial unpaid care.

6.a	Is there an informal carer supporting you?		
6.b	Has the informal carer received a carer assessment of their own?		
6.c	If Yes to 6.b, does the assessment need to be reviewed/re-assessed?		
6.d	If No to 6.b, would the carer like to be referred for a carers assessment? If no what is the reason		

## 7.0 DIRECT PAYMENT

Ref No		Yes	No
7a	Do you receive a Direct Payment?		
7b	If No to 7.a, would you like to consider receiving a Direct Payment?		
7c	If Yes to 7.b, would you like to be referred to the support organisation DPSS ?		

## 8.0 INDEPENDENT LIVING FUND (ILF)

Ref		Yes	No
8a	Do you receive ILF?		
8b	If No to 8.a and you are eligible for ILF, would you like more information about ILF?		

**9.0 ONLY APPLIES IF YOU RECEIVE SERVICES FROM THE LEARNING DISABILITY PARTNERSHIP.**

Ref No		Yes	No
9.a	Do you have a Health Action Plan		
9.b	Has a person centred plan been completed with you?		
9.c	Are you in paid Employment? if so do you work 30hrs or more, more than 16hrs but less than 30 hrs, more than 4 but less than 16hrs more than 0 but less than 4 hours a wk.		
9.d	Are you in unpaid voluntary work?		
9.e	Are you in settled accommodation e.g - supported - accommodation, lodgings, group home. Extra care sheltered or sheltered accommodation, tenant or registered home, tenant private landlord, mobile accommodation, - gypsy/roma and traveller, owner occupier or shared owner scheme.		

Ref No	ACTION TO BE TAKEN	BY WHOM	WHEN

ACTION TO BE TAKEN FOLLOWING YOU REVIEW / REASSESSMENT

IF THERE ARE CHANGES TO BE MADE TO YOUR CARE PLAN, A NEW CARE PLAN WILL BE PRODUCED AND A COPY SENT YOU.

DATE OF NEXT RVIEW / RE-ASSESSMENT:

As part of my review, I agree to information about my care needs being requested from, and shared with other agencies involved in providing the care I need

YES ☐ NO ☐

I consent to a copy of my complete review record being shared with everyone who has contributed to it (see page one)

YES ☐ NO ☐

SERVICE USER SIGN TO CONFIRM THAT THIS REVIEW HAS TAKEN PLACE : ..... DATE: .....

CARE MANAGER/REVIEW OFFICER SIGN TO CONFIRM REVIEW  
DATE: .....

TAKEN PLACE .....

## WHAT HAPPENS NEXT

Your review / re-assessment will be typed up and a copy sent you. If you require your assessment to be in an alternative format, this can be arranged by your care manager / review officer.

If you would prefer a copy of your review / re-assessment is sent to a representative this can be arranged.

You will have an opportunity to read the information and make any amendments or add any appropriate comments before signing in the box below and returning it to your care manager / review officer.

### SERVICE USER AGREEMENT TO CONTENT OF REVIEW / RE-ASSESSMENT

I have received a copy of my review YES ☐ NO ☐

I understand and accept the results of my review YES ☐ NO ☐

What has been recorded in my review is an accurate statement about my social care needs YES ☐ NO ☐

Comments:

.....

.....

.....

.....

Signed: .....  
(Service User / Carer – delete as appropriate)

Print Name: .....

Date:.....

OFFICE USE ONLY

Signed: ..... Date: .....  
(Assessor / Reviewer)

Print Name: .....

Job Title: .....

Team/Unit: .....

Signed: ..... Date: .....  
(Authorising Manager)

Print Name: .....

Job title: .....

Details of re-assessment entered on SWIFT Yes Date

Review entered on SWIFT Yes Date

Altered provisions entered on SWIFT Yes Date

Date of next review entered on SWIFT Yes Date

Copy of review sent to Service User: Yes Date

Unmet needs form completed (if appropriate): Yes Date

Copies of review sent to review participants Yes Date  
(see page 1)

If 'No' – copies must be sent once Service  
User's consent given

Actions/Recommendations agreed by Yes Date  
Practice / Locality manager  
If 'No' – what steps have been taken?

Signed: ..... Date: .....  
(Practice/Locality Manager)

**PAGE  
NUMBERING  
AS  
ORIGINAL**

SERVICE USER NAME:

SWIFT ID:

SOC 368 (Rev Jan 09)

ADULT REVIEW / RE-ASSESSMENT

1.0 SERVICE USER DETAILS

Full Name :

Address:

Date of Birth :

SWIFT ID :

Review / Re-Assessment date:

Date of last Review/Re-Assessment date:

Services related to this Review/Re-Assessment (tick box(es))

Domiciliary service ☐

Nursing Home ☐

Supported living ☐

Day support ☐

Direct Payments ☐

Residential Care ☐

Sensory Equipment ☐

Other please specify

Type of Review/Re-assessment : Meeting ☐

Telephone ☐

Change of details (eg – Accommodation/Contact/GP/Name/Relationship

Status/Other(specify):

New Details:

Date of Change

2.0 REVIEW INVOLVEMENTS

NAME ROLE AND RELATIONSHIP	Attended = A Consulted = C Invited not attended = I	Consent given by Service User to share content of review



**SERVICE USER NAME:**

**SWIFT ID:**

**4.0 RE-APPRAISAL OF ELIGIBILITY**

The chart below is the 'Fair Access to Care Services' eligibility criteria. Your Care Manager/Review Officer will explain how it is used to identify eligibility, and then briefly describe your eligibility status in the appropriate box(es).

		LEVEL OF RISK			
Description of Need		Low (1)	Moderate (2)	**Substantial (3)	**Critical (4)
<b>A</b> Physical safety of the individual or others		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B</b> Physical health/disability of the individual or others		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C</b> Mental health of the individual or others		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>D</b> Independent living skills		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E</b> Involvement in work, education, training		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F</b> Social roles, relationships and responsibilities		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4.a: Is the Service User still eligible for services ?**    Yes

**4.b: Does the current provision meet the needs and support the outcomes?**    Yes

## 9.0 9a and 9b only apply if you receive services from the Disability Service.

Ref No		Yes	No
9a	Do you have a Health Action Plan (Learning Disability only)	<input type="checkbox"/>	<input type="checkbox"/>
9b	Has a person centred plan been completed with you? (Learning Disability only)	<input type="checkbox"/>	<input type="checkbox"/>
9c	Are you in paid employment? If so, do you work: <ul style="list-style-type: none"> <li>• 30 hours or more a week</li> <li>• More than 16 hours, but less than 30 hours a week</li> <li>• More than 4 hours, but less than 16 hours a week</li> <li>• More than 0 hours, but less than 4 hours a week.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
9d	Are you in unpaid voluntary work?	<input type="checkbox"/>	<input type="checkbox"/>
9.e	Are you in settled accommodation? (eg : supported accommodation, lodgings, group home, extra care sheltered, sheltered accommodation, tenant of registered home, tenant private landlord, mobile accommodation, gypsy/roma/ traveller, owner/ occupier, shared ownership scheme.	<input type="checkbox"/>	<input type="checkbox"/>

**WHAT HAPPENS NEXT**

Your Review/Re-Assessment will be typed up and a copy sent you. If you want this prepared in a different format, this can be arranged by your Care Manager / Review Officer.

If you would prefer a copy of your Review/Re-Assessment to be sent to a representative your Care Manager / Review Officer can arrange this.

You will have an opportunity to read the information and make any amendments and add comments before signing in the box below and returning it to your Care Manager / Review Officer.

**SERVICE USER AGREEMENT TO CONTENT OF REVIEW / RE-ASSESSMENT**

I have received a copy of my Review YES ☐ NO ☐

I understand and accept the results of my Review YES ☐ NO ☐

What has been recorded in my Review is an accurate statement about my social care needs YES ☐ NO ☐

Comments:

.....

.....

.....

.....

Signed: .....  
(Service User / Carer – delete as appropriate)

Print Name: .....

Date: .....